OFFICE FINANCIAL POLICY

BASIC POLICY:
Payment for service is due in full at the time the service is provided in our office unless we are a member of your insurance group (please contact your insurance company regarding covered members) or prior arrangements have been made with this office.

FOR PATIENTS WITH INSURANCE:
If we are members of your insurance group we will bill the insurance carrier for payment to come directly to us. You will be responsible for co-payments and deductibles only. **All co-payments and deductibles are due and payable at the time service is provided.**

If we are not members of your insurance group we will bill most insurance carriers for you if the proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Payment for these claims will come directly to us. If our office can be of any assistance with your insurance carrier please let us know.

MEDICARE PATIENTS:
Our office accepts Medicare assignment. We will also bill secondary insurances for you. All co-payments and deductibles are due and payable at the time service is provided.

NON-COVERED SERVICES:
Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

ASSIGNMENT AND RELEASE: I, the undersigned, have insurance coverage and assign directly to Central Arkansas Pain Center all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the office of Central Arkansas Pain Center to release all information necessary to secure the payment of benefits or to pre-certify their services as required by my insurance company. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made to Central Arkansas Pain Center for any services furnished me by any member of this clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown. In Medicare, assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the determination of the Medicare carrier.

_____ _____
Signature of Insured/Guardian/Beneficiary **Date**

I have read, understood and agreed to the above financial policy for payment of professional fees. I understand that I, the patient, am ultimately responsible for all professional fees.

Signature: _____ **Date: _____**