

## FINANCIAL POLICY

This is an agreement between North Lakes Pain Consultants (NLPC), as creditor, and the Patient/Debtor named on this form. In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us" and "our" refer to NLPC. By executing this agreement, you are agreeing to pay for all services rendered.

**CO-PAYMENTS REQUIRED BY AN INSURANCE COMPANY MUST BE PAID AT THE TIME OF SERVICE.  
THIS IS AN INSURANCE REQUIREMENT; WE CANNOT BILL YOU.**

**Contracted Insurance:** NLPC must comply with our contracts and any requirements set there in. It is the insurance company that makes the final determination of your eligibility/benefits. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in no payment or a lower payment from the insurance company. Ultimately, you are responsible for unpaid amounts.

Payment options for contracted insurance:

1. Pay by cash, check, or credit card. All major credit cards accepted.
2. Treatment involving procedures – Pay in full or pay 1/3 of your out-of-pocket portion on the date of service and the rest within the payment schedule arrangement. The Business Office must be contacted to set up the payment schedule arrangement and a Payment Arrangement Letter must be signed.

**Non-contracted Insurance:** Your insurance coverage is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility/benefits. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in no payment or a lower payment from the insurance company. You agree to pay any portion of the charges not paid by your insurance.

Payment options for non-contracted insurance:

1. Pay by cash, check, or credit card. All major credit cards accepted.
2. Treatment involving procedures – Pay in full or pay 1/3 of your out-of-pocket portion on the date of service and the rest within the payment schedule arrangement. The Business Office must be contacted to set up the payment schedule arrangement and a Payment Arrangement Letter must be signed.
3. You may choose to file your own insurance. In this case see Payment Options if you have no insurance.

**No Insurance:** This means you are not currently covered under any government/commercial insurance plan or NLPC is not currently contracted with your insurance company.

Payment options if you have no insurance:

1. Pay by cash, check, or credit card on the day that treatment is rendered. Charges will be set at the cash pay discount rate. If for any reason full payment is not received on the date of service, the cash pay discount rate will not apply.
2. Payment plan - pay 1/3 of your out-of-pocket portion on the date of service and the rest within the payment schedule arrangement. The Business Office must be contacted to set up the payment schedule arrangement. A Payment Arrangement Letter must be signed. **The cash pay discount does not apply to payment plans.**

**Cancellation of insurance:** If your insurance company states that your policy has been cancelled and you no longer have coverage the bill will be due in full by the patient.

**Account Statement:** If you have a balance on your account, we will send you a statement. It will show separately the previous balance, any new charges to the account and payments or credits applied to your account during the month. Unless other arrangements are approved by us in writing, the balance is due when your statement is issued, and is past due if not paid by the end of the month.

**Charges to Account:** We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

**Past due accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If your account is referred to a collection agency, you agree to pay all of the collection costs which are incurred.

**Returned checks:** A \$25 fee will be incurred for any checks returned for non-sufficient funds by the bank.

**Workers Compensation:** Complete WC information is required. The required information includes but is not limited to your employer, date of injury, claim #, adjuster, WC Carrier and all necessary contact phone numbers. We require written approval/authorization by your worker's compensation carrier prior to your visit. Once your claim is determined to be finally adjudicated you must provide updated billing information such as private health insurance.

**Medical Records:** Patients may obtain a copy of their medical record upon request. The first copy of your medical record is free, if picked up from one of our office locations. If you would like your medical record mailed you are required to pay for postage prior to the records being sent. There will be a \$15 charge for each additional medical record request.

**No Show Policy:** A No Show is failure to attend a scheduled appointment without calling to cancel the appointment at least 24 hours in advance, unless due to emergency.

1. 1<sup>st</sup> No Show - policy reminder mailed to patient.
2. 2<sup>nd</sup> No Show - \$25 fee.
3. 3<sup>rd</sup> No Show - you will receive a letter dismissing you from the practice. A similar letter will be sent to the referring physician.

**In each of the above scenarios, as the patient, you are ultimately responsible for all liable amounts.**

**Waiver of confidentiality:** You understand received treatment at our office may become a matter of public record, if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency.

**Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Print Name: \_\_\_\_\_ Responsible Party (if not patient): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_