RESTORATIVE
PAIN CARE

Restorative Pain Care believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We provide the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT -** is expected at the time of your visit. (This includes Copayments, Deductibles, Coinsurance, Missed Appointments; unpaid balance after insurance has paid their portion, Past Due, etc.). If you are unable to make a full payment Restorative Pain Care reserves the right to reschedule your appointment for a later time when you are able to make your full payment, (any payment due or owed at time of service). We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, payment in full is expected at the time of your visit. We do ask for a copy of an ID card or license and insurance cards.

2. **INSURANCE -** We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore you are responsible for sending this payment to Restorative Pain Care. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

Restorative Pain Care only has a specific amount of time to submit a claim to your insurance carrier. If your coverage/insurance company changes and we bill your old carrier we may miss the time limit to process the claim. In this case the claim becomes your responsibility for payment, so please notify us immediately if your coverage changes so that we can accurately submit the claims.

3. **COLLECTION -** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Restorative Pain Care reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay Restorative Pain Care for any expenses we incur to collect on your account, including attorney fees, collection fees, and contingent fees to collection agencies. Contingency fees will be added and assigned to the collection agency immediately upon our referral of your account to the collection agency of our choice. You agree that in order for us to service your account or to collect any amounts you may owe, we may contact you by phone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded voice messages and/or use of an automatic dialing device.

4. **RETURNED CHECKS -** will incur a $40.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $40 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments or overturned chargebacks on your credit card constitute a breach of payment and are subject to the $40 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Maricopa County.

5. **ACCOUNTING PRINCIPALS -** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

6. **FORMS AND CONSULTS FEES -** Completing insurance forms, copying medical records, etc. requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. On occasion, our staff may be asked to provide a deposition and/or other testimony or actions concerning your care. There is a separate fee schedule for such activity. The fees for such activity are to be paid by the patient regardless of the party requesting the activity.

7. **CANCELLATIONS OR MISSED APPOINTMENTS -** If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $25 missed appointment fee. If you do not cancel your procedure with at least 24 hours' notice, you will be assessed a $150.00 missed procedure fee. Any missed visits may result in discharge from the practice.

8. **RESPONSIBILITY FOR PAYMENT -** I understand that I, personally, am financially responsible to Restorative Pain Care for charges not covered by the assignment of insurance benefits.

9. **ASSIGNMENT OF INSURANCE BENEFITS -** I hereby assign, transfer, and set over directly to Restorative Pain Care sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs

of the care and treatment rendered to myself or my dependent in said practice. I authorize Restorative Pain Care to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Restorative Pain Care. I authorize Restorative Pain Care to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third- party payers.

I have read and understand the practice's financial policy of Restorative Pain Care and I agree to be bound by its terms. I understand that I am financially responsible for ALL services I receive from Restorative Pain Care. I hereby assign all medical and surgical benefits and authorize my insurance carrier (s) to issue payment directly to Restorative Pain Care. This financial policy is binding upon you, your estate, executors and/or administrators, if applicable.

I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient (or Guarantor)_____ Date_____

Please print the name of the patient _____