



***PainCARE* OFFICE POLICY**

Thank you for choosing *PainCARE* as your pain management provider. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Office Policy that we require you read and sign prior to any treatment. All patients must complete our demographic, insurance and medical forms prior to seeing a provider. **Remember that appointment times are guidelines only. The physician will spend as much time as needed to fulfill each individual patient's needs. For this reason, slight delays may occur in the daily schedule.**

PainCARE does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: Kelly Travis, 913-901-8880.

ANY PERSON RECEIVING A PROCEDURE IN OUR OFFICE WILL NEED A DRIVER. Without a driver your procedure will be canceled.

Medication Refills: Our office **CANNOT** refill any prescription after 3 pm on any weekday, on weekends, or on holidays. You are responsible for planning your medication needs so that you will not run out on weekends, long weekends, or holidays.

No controlled substance prescriptions will be filled on an initial visit.

Pre-certification / Authorization / Referrals: Pre-certification and authorizations of procedures will be done by our staff providing we have all of your insurance information. Referrals for office visits are the patients' responsibility. If you are seen without a required referral, payment will be expected from you.

Regarding Insurance: We may accept assignment of insurance benefits. **However, we do require any co-pay or remaining portion of the bill to be paid in full at the time of service.** We cannot bill your insurance company unless you give us accurate insurance information in full, including a copy of your card at or before your first visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Our relationship is with you, not your insurance provider. Please understand the benefits your insurance or health plan provides for physician office visits. It is your responsibility to know what services are covered. If you are unsure, check with your employer or call your insurer. In the event that your insurance coverage changes to a plan where we are not a participating provider or lapses, payment for additional services or any remaining balance will become your responsibility. If you receive services without informing our office of any of these changes, you will be responsible for the cost of these services. Again, **please let us know, as soon as possible, if you have any change in insurance plan, coverage, provider, employment, address or phone numbers.**

Release of Information and Authorization to Pay Insurance Benefits: This office may disclose all or any part of your medical record to any group or organization, which is or may be liable for payment of all or part of the office's charges, including, but not limited to, insurance companies, medical or hospital services companies, workers' compensation carriers or employers. Your signature at the end of this form authorizes *PainCARE* to obtain any holder of medical or other information about you and to release to the Social Security Administration or its intermediaries or carriers any information needed for this or any related Medicare claim. Your signature also means you request that payment of authorized Basic Benefits, as well as Major Medical Benefits, be made on behalf of the patients directly to said providers.

Financial Policy: If you do not have insurance, all payments are expected at the time of service. If you do have insurance, all deductibles and co-payments are expected at the time of service. If your carrier has not paid a claim within sixty days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety days of submission, you accept responsibility for payment in full of any outstanding balance. If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claims submitted. The purpose of our financial policy, indicated by your signature below, allows you to assign your insurance benefits directly to us.

Usual and Customary Rates: Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

Payment options: *PainCARE* accepts Cash, Checks, MasterCard, Visa, or Discover. A service charge is computed by a ‘periodic rate’ of 1.5% per month – 18% per annum and is added to all balances owed 60+ days. Any balance past due 90 days or more will be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, costs related to but not limited to all collection related expenses, attorney fees, court & filing fees. Returned checks, debit and credit charges made payable to *PainCARE* for insufficient funds, stop payments or other reasons of non-payment will be assessed a \$30.00 charge.

Informed Consent for Treatment: By signing below you give your consent for services for yourself or your child/legal dependant, provided by *PainCARE* and associated members of the professional staff to include evaluation, medication management, testing (if indicated), interventional procedures, physical therapy evaluation and treatment, and involvement in the treatment planning process. You may at any time decline specific recommendations.

Signature of Patient or Responsible party signifies agreement to each policy above.

Responsible Party’s Signature
(Patient, if adult; Parent/Guardian,
if patient is a minor)

Printed Name of Signee

Patient Name
(If other than responsible
party)

Date