Pain Treatment Associates, LLC **Patient name: _______________DOB:____________**
Your Pain Management Specialists •1410 Doctors Drive •West Plains, MO 65775 Phone: (417) 256-BACK

FINANCIAL POLICY

Thank you for choosing PAIN TREATMENT ASSOCIATES, LLC as your health care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our business office personnel. We ask that all patients read and sign our Financial Policy prior to seeing a medical care provider.

Patient's portion of payment, including co-pay, co-insurance, deductible, and/or existing account balance or account balance of immediate family is due at the time services are rendered unless prior arrangements have been made with the business office manager or personnel.

We accept assignment with most major insurance companies and participating provider plans. However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier.
2. All charges are your responsibility whether your insurance company pays or not.
3. Fees for services, along with unpaid deductibles, co-insurance, and co-payments, are due at the time of treatment.
4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.
5. Returned checks are subject to $25.00 collection charge. We will notify you by letter or phone. If the check is not picked up within 10 days, the check may be turned over to law enforcement.
6. Unpaid balances over 90 days may be subject to collections via small claims court, attorney, and/or collection agency with applicable collection fees. All collection fees are the responsibility of the patient.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Unless there is 24-hour notice for a canceled appointment you will be charged a NO SHOW FEE of $25 that must be paid prior to being allowed to schedule any future appointments. Please be advised NO SHOWS could result in dissolution of care.

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to PAIN TREATMENT ASSOCIATES, LLC the medical and/or surgical benefits I am entitled from insurance company(s), attorney(ies), and/or Medicare, and Medicaid.

This authorization is in effect for all future claims, until I choose to revoke it in writing.

I agree that the facility, Pain Treatment Associates, LLC, or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment. I have had the opportunity to ask and have my questions answered to my satisfaction.

____ ____________________
Patient's Signature Date

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Authorized Signature (legal guardian or power of attorney)