Apex
PAIN SPECIALISTS

Condition of Services and Financial Agreement

Benefit Release Information:

- I authorize **Apex Pain Specialists PC** to release any information necessary to my insurance carrier and/or their agents in order to determine benefits payable for related services.
- I authorize the payment of medical benefits for these services to be paid directly to **Apex Pain Specialists PC.**
- I authorize the release of all clinical information to my referring physician and primary care physician so that he or she can be updated on my condition and the care I receive here.

Initials: _____

Financial Responsibility:

I am the person financially responsible for any debt in relation to services provided.

- I understand and agree to pay all insurance co-pays and amounts due for services not covered by insurance in advance at the time of service.
- I understand and agree that, except as otherwise provided by law, I am obligated to pay any charges that are not paid by my insurance company within 60 days or immediately upon denial by my insurance company.
- Should this account be referred to any attorney, I agree to pay reasonable attorney's fees.
- Should this account be referred to a collection agency I agree to pay a collection charge of 35% of the balance submitted to collection. All delinquent accounts are eligible to bear interest.
- It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required, if preauthorization is required prior to a procedure, and what services are covered.
- If Apex Pain Specialists, PC does not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
- Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.
- If you participate with a high-deductible health plan, we require a copy of the health savings account debit/credit card or a personal credit card remain on file. There are addenda to this financial policy, which are signed separately.
- We do not accept personal checks for new patient visits. We require these payments to be made by cash or credit card.

Initials: _____

Authorization of treatment:

I authorize **Apex Pain Specialists PC** to provide medical services to myself or to _____ (my legal dependent). I understand I have the right to refuse medical services at any time. I further understand no guarantees have been made by any representative of **Apex Pain Specialists PC** as to the outcome of this medical service.

Initials: _____

Cancellations and No-Shows:

- We require 24 hours notice of a cancellation of an initial or follow-up visit. There will be a $50.00 charge for a cancellation or no show of an initial or follow-up visit without proper notice.
- We require 48 hours notice of a cancellation of a scheduled procedure. There will be a $100.00 charge for a cancellation or no show of a scheduled procedure without proper notice.
- These charges will not be covered by your insurance plan and are your responsibility.
- For Worker's Compensation patients, you are required to document any cancelled or missed appointments and forward them to your case manager and primary care physician.

Initials: _____

Patient Name: _____ DOB: _____

Signature: _____ Date: _____
(If the patient is a minor, please have the parent/guardian sign here.)