Financial Policy

You are financially responsible for the medical services you receive at Arizona Pain Specialists, PLLC (hereafter referred to as the "Practice"). Please carefully review this Financial Policy, initial each section and sign the agreement to indicate your acceptance of its terms.

APPOINTMENTS

1. **Copayments and Deductibles**. Copayments and deductibles for clinic visits are due at the time of service, in accordance with your insurance carrier's plan. If you are unable to make your copayment at the time of service, the Practice reserves the right to reschedule your appointment until such time that you are able to make your copayment.

2. **Procedure Prepayment**. The Practice may collect your payment for a procedure at the time the procedure is scheduled. Your prepayment is based on an **estimate** of your expected financial responsibility. We reserve the right to reschedule your procedure until prepayment arrangements have been made. You are responsible for any unpaid balance after your insurance carrier has processed your claim. In the event of overpayment, you may request a refund.

3. **Self-Pay.** If you do not have health insurance, or if your health insurance will not pay for services rendered by the Practice or if you notify us not to contact or bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available at our front desk). Payment is due in full at the time of service.

4. **Missed Appointments and Late Arrivals**. You will be charged a fee for each incident according to the Public Fee Schedule. These charges are your personal responsibility and will not be billed to any insurance carrier. **Initial: _____**

INSURANCE PAYMENTS

5. **Financial Responsibility.** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurance carrier will be your responsibility, except as limited by the Practice's specific network agreement with your insurance carrier, if such an agreement is in place.

6. **Coverage Changes and Timely Submission.** It is your responsibility to timely inform us of any change to your billing or insurance information. Your insurance carrier places a time limit within which the Practice can submit a claim on your behalf. If the Practice is unable to process your claim within this period due to your providing incorrect insurance information or not responding to insurance carrier inquiries, you will be responsible for all charges.

Initial: _____

BENEFITS AND AUTHORIZATION

7. **Insurance Plan Participation.** The Practice has specific network agreements with many insurance carriers, but not all insurance carriers. It is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your plan. Your insurance carrier's plan may have out-of-network charges that have higher deductibles and copayments, which you will be responsible for.

8. **Referrals.** Referral and prior authorization requirements vary among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by the Practice, it is your responsibility to obtain this referral prior to your appointment. Although, your referring health care provider, and the Practice, are expressly permitted to disclose your Protected Health Information (PHI) for your treatment, under HIPAA, you have the right to request restrictions on the disclosure of your PHI. Under HIPAA, the Practice is not required to agree with you.

   As a matter of course, the practice will inform your referring physician of your patient care plan and progress either by using any secure electronic transmission machine or by an employee of the Practice.

9. **Prior Authorization and Non-Covered Services.** The Practice may provide services that your insurance carrier's plan excludes or require prior authorization. The Practice, as a courtesy to our patients, will make a good-faith effort to determine if services we provide are covered by your insurance carrier's plan, and, if so, determine if prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf. Ultimately, it is your responsibility to ensure that services provided to you are covered benefits and authorized by your insurance carrier.

10. **Out-of-Network Payments and Direct Insurer Payments.** You are personally responsible for all charges. If we are not part of your insurance carrier's network (out-of-network) or your insurance carrier pays you directly, you are obligated to forward the payment or payment proceeds to the Practice immediately. **Initial: _____**

ACCOUNT BALANCES AND PAYMENTS

11. **Reassignment of Balances.** If your insurance carrier does not pay for services within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. **Balances are due within 30 days of receiving an initial statement.**

12. **Collection of Unpaid Accounts.** 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 for collection. This may result in adverse reporting to credit bureaus and additional legal action. **The Practice reserves the right to refuse treatment to patients with outstanding balances over 120 days old.** You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you at any telephone number associated with your account, including cellular numbers, which could result in charges to you. We may also contact you by text message or e-mail, using any e-mail address you provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device.

13. **Returned Checks.** You will be charged for returned checks according to the Public Fee Schedule.

14. **Refunds.** Refunds for overpayment are processed only after full insurance reimbursement of all medical services has been received. Please submit a written refund request and allow 6 weeks for your request to be processed. Send requests to: Arizona Pain Specialists, Attn: Billing Department, 9977 N 90th St., Ste. 320, Scottsdale, AZ 85258- 5088.

15. **Statements.** Charges shown by statement are agreed to be correct and reasonable unless protested in writing within 30 days of the receipt. **Initial: _____**

ADDITIONAL FEES

16. **Medication Refill Requests.** All medication refill requests are to be approved by your provider. A fee will be charged according to the Public Fee Schedule for any of the following requests: lost prescriptions; urgent refill/office visit requests (same or next business day); and refills processed after a missed appointment.

17. **Medical Records Requests**. The Privacy Rule allows you to receive a copy of your personal medical records, billing records and allows the Practice to require individuals to complete and sign an Authorization for Disclosure and Release of Medical Records Form. However, if you are unable to come into one of the Practice's clinics, the Practice will make every accommodation to fulfill your request. A fee will be charged for medical records requests according to the Public Fee Schedule. There is no charge to transfer a copy of your medical records to a new Provider

18. **Other Forms.** The Practice will respond (at the provider's discretion) to requests for the completion of certain medical forms (FMLA, Short Term Disability & Temporary Disability Parking Permit) assuming the patient is in good standing and has been active with the Practice for six (6) months consecutively. Other forms not listed may be considered for completion by the Practice. In these cases, the fee will be determined by the Practice manager. All requests require an office visit. **Initial: _____**

19. **Acknowledgment of Notice of Privacy Practice**. By initialing this section, I acknowledge that I have received and reviewed a copy of the Practice's Notice of Privacy Practice. **Initial: _____**

20. **Public Fee Schedule.** By initialing this section, I acknowledge that I have received a copy of the Practice's Public Fee Schedule. **Initial: _____**

Practice Code of Conduct

We are pleased to serve you and glad that you chose Arizona Pain as your new pain management provider. We will always strive to provide exceptional care for you.

Reasons that Arizona Pain may ask you to seek health care services elsewhere might include:

- Rude or violent behavior to staff via in-person or telephone - this also applies to your family members and/or friends
- Repeated no shows, cancellations, or continual late arrivals for office visits or procedures
- Refusal to adhere to the plan of care as outlined by your Clinician or to follow health insurance or government guidelines
- Unwarranted requests for disability paperwork

Our goal is to help you. Therefore, we ask that you schedule and keep all follow up appointments, participate in all treatments and diagnostic testing. **Initial: _____**

Agreement and Assignment of Benefits

I have read and understand the Financial Policy of Arizona Pain Specialists, PLLC, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to the Practice. I understand that I am financially responsible for all services I receive from the Practice. This financial policy is binding upon me and my estate, executors and/or administrators, if applicable.

Printed Name: _____

Signed:_____ Date: _____