Financial Policy

Physician Pain Care is committed to meeting your health care needs. The following statements explain our Financial Policy. Please read, sign and return to us prior to your treatment.

1. You are ultimately responsible for payment of charges for services you receive from our office. You are responsible for providing accurate and complete personal and insurance information prior to receiving services. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service.
2. **You are responsible for obtaining your referral** (if necessary) to our office, and if you are seen without a valid referral you will be responsible for payment of the visit.
3. We participate with most insurance plans. However, your insurance policy is a contract between you and your carrier. It is your responsibility to ensure that treating physicians are in your insurance network.
4. Payment is due at the time of rendered services. Unpaid personal balances must be paid in full prior to receiving additional treatment.
5. If we are denied payment after billing your insurance, you will be responsible for payment of these services.
6. **All copayments and deductibles are due at the time of visit.** If you are unable to pay your copayment at the time of your visit, you will need to reschedule your appointment.
7. The fee for returned checks is $30 and must be paid prior to any additional services.
8. We accept Master Card, Visa, and Discover cards.
9. **Cancellations for appointments or procedures must be received at least 24 hours prior to the scheduled appointment.** We reserve the right to charge $25.00 for any "no show" appointments and $50 for any "no show" procedures.
10. Past Due Accounts may be referred to a collection agency. Any legal fees that we pay to secure past due balances will be added to your account. If your balance exceeds $200—please see our financial counselor for assistance.
11. If you are not compliant with this agreement, this will be grounds for immediate dismissal from the practice.

By signing this document, you understand that you will be bound by this agreement and that you have read, understood, and accepted these terms.

Signature: ________________________________ Date: ________________________

Printed Name: ______________________________