Emerald Coast Pain Services

Financial Policy

ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes direct payment to the center and/or associates provider of service of any insurance benefits, third party payments or other applicable benefits such as Medicare other wise payable to the undersigned for these outpatient services at a rate not to exceed its/their regular charges. It is agreed that payment to the center and/or associated providers of service, pursuant to this authorization, by an insurance company shall discharge said insurance company for any and all obligations under a policy to the extent of such payment. It is further understood by the undersigned that he/she is financially responsible for charges not collected by this assignment unless otherwise stated by applicable written contract or law. The undersigned also acknowledges that the center and /or associated provider of service have agreed to bill his/her insurance or other third party as a courtesy and that total charge; may be considered due and payable at any time.

RELEASE OF INFORMATION: The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, the center may disclose portions of the patient's record, including his/her medical record to any person or entity which is or may be liable for all or any portion of the center's charges, including but not limited to government agencies such as Medicare, insurance companies, health care services plans or worker's compensation carriers as well as those individuals the board of managers deem appropriate to review the medical record for purposes of medical quality assurance/improvement and peer review. A photocopy of this authorization shall be considered as effective and valid as he original.

FINANCIAL AGREEMENT: The undersigned agrees that in consideration of the services to be rendered to the patient he/she hereby individually obligates himself/herself to pay the account of the center and/or associated provider of service in accordance with the regular rates and terms of the center and/or associated provider of service. Should the account be referred to any attorney or collection agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses to include interest.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance will be automatically transferred to patient responsibility. Please be aware that some and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment is expected at the time services are rendered unless prior financial arrangements have been made. <u>Our fee is solely the fee for the physician.</u> The surgical facility charge, pathology or durable medical equipment in NOT included in this fee. Any deposit made will be applied to our charges.

I have read the Financial Policy. I understand and agree to this Financial Policy.

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Signature of Patient or Guardian (and relationship) Date

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Witness