

PAYMENT POLICY

Thank you for choosing **Pain Specialists of Orange County** for your pain management needs. It is our goal to provide you with the best quality of care. Below you will find our payment policy. Please read it and feel free to ask us any questions so that we can resolve any financial concerns you may have prior to the onset of your treatment with us. Please sign at the bottom in the space provided.

Proof of Insurance: All patients must provide us with a valid insurance card and a valid government issued photo identification at the time of service. This is a CMS requirement as well as a protective measure for you. Should you have any changes with your insurance please contact us immediately to ensure your information is properly updated prior to your appointment(s). Failure to provide us with correct information in a timely manner may result in your being financially responsible for any and all charges denied by your insurance.

Deductible, Co-Payment, Co-Insurance: Your health insurance is an agreement between you and the carrier providing coverage for you. Your policy requires us to collect all deductibles, co-pays and co-insurance amounts that are listed as your responsibility. Your cost share amounts are due at the time of service. As a courtesy, we verify your benefits prior to your visit and do our best, based on the information provided, to estimate your responsibility. You should be aware all insurance companies provide a disclaimer that verification of coverage is not a guarantee of payment and all claims are subject to policy benefits, limitations and exclusions in effect during the adjudication process. The amount we collect on the day of your visit may be adjusted up or down after your claim is processed and finalized by your insurance company. If you are found ineligible for coverage of plan benefits, you will be financially responsible for the cash rate of all costs incurred during the delivery of health services.

Claims Submission: As a courtesy, we submit your claims and assist you in any way we reasonably can to get your claims paid by the insurance company. However, your insurance company may request additional information directly from you. It is your responsibility to provide your insurance with the requested information in a timely manner. Failure on your part to respond to an insurance request may result in you being held financially responsible for any and all charges not paid by your insurance. If you are found ineligible for coverage of plan benefits, you will be financially responsible for the cash rate of all costs incurred during the delivery of health services.

Facility Charges: It is important for you to understand there is a difference between seeing our physicians for an office visit (professional) and receiving services from our physicians in one of our Ambulatory Surgery Centers (ASC) (facility). Any time you receive services in one of our ASCs, you will receive a separate bill for your financial responsibility for services provided in the ASC. When services are provided at one of our ASC's, you may have a facility and a professional cost share. Payments made towards office visits do not cover your financial responsibility for services provided in one of our ASC's.

Cash Rate Charges: Cash rates will be provided if you are uninsured or opt out of using your own insurance plan. Payments must be made in full prior to or at the time of service. Cash rate payments will not apply to deductibles, co-payments, co-insurance, or any out-of-pocket expenses.

Missed Appointments: As a courtesy to our Physicians and other patients, we ask that you **cancel your appointment 24 hours prior to the scheduled time**. Missed appointments that are not cancelled 24 hours prior will be **subject to a \$50.00 missed appointment fee**. This fee must be paid immediately and may cause an interruption in care should it not be paid.

Thank you for taking the time to review our Payment Policy. We appreciate your understanding of our policy and practices for our office. Please let us know if you have any questions or concerns.

I have read and understand the Payment Policy and agree to abide by its guidelines:

Signature of Patient or Responsible Party

Date