Northeast Pain Management
Absolute Physical Therapy
*Setting the Standard.*

*Minimally Invasive Spine Care*
*and Physical Therapy*
*with*
*Expert Treatment*
*Timely Appointments*
*Cost-Effective Services*

**FINANCIAL POLICY**

This is an agreement between Northeast Pain Management, P.C., as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to Northeast Pain Management, P.C.

By executing this agreement, you are agreeing to pay for all services that are received.

**MONTHLY STATEMENTS:** If you have a balance on your account, we will send you a monthly statement. It will show the dates of service with existing balances due by both the Patient/Debtor and or their insurance. If you have an appointment and have not yet received your statement you will be asked for the balance due at that time, we can provide a copy of the statement if needed.

**PAYMENTS:** Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within **30** days.

**CHARGES TO ACCOUNT:** We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service. At no point will patients be allowed to carry a balance of more than **$300.00**.

**REQUIRED PAYMENTS:** Any co-payments required by an insurance company must be paid at the time of service. Patient's with an annual deductible greater than **$500.00** will need to provide a deposit of **$300.00** at the time of service.

**INSURANCE:** Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your insurance company as a courtesy to you. Although we may estimate with your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company required a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

**PAST DUE ACCOUNTS:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees, which we incur, plus all court costs. In case of suit, you agree the venue shall be in Penobscot County, Maine.

**RETURNED CHECKS:** There is a fee (currently **$25.00**) for any checks returned by the bank.

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**FINANCIAL POLICY CONTINUED**

**WAIVER OF CONFIDENTIALITY:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

**WORKERS COMPENSATION:** We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

**PERSONAL INJURY:** If you are being treated as part of a personal injury lawsuit or claim, including a motor vehicle accident, we require verification from your attorney or the responsible party prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial agreements may be discussed. We may require a letter of protection from your attorney. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury.

**TRANSFERING OF RECORDS:** You will need to request in writing if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requested records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

**EFFECTIVE DATE:** Once you have signed the acknowledgement of receipt from, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

**CONSENT TO TREAT AND AUTHORIZATION TO RECEIVE PAYMENT**: By signing, the acknowledgement of receipt for this agreement, I consent to treatment by Northeast Pain Management, P.C., and I authorization Northeast Pain Management, P.C., to directly receive payment of benefits from an insurer, managed care organization, governmental agency or other third party that is responsible for payment or arranging for payment of the health care services provided to me by Northeast Pain Management, P.C. I understand that I may be responsible for the payment of the health care services furnished to me by Northeast Pain Management, P.C., even though I may be covered under an insured or other plan arrangement. I also consent to review of my Medication History by Northeast Pain Management, P.C.

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**Acknowledgement of Review of Notice of Privacy Practices:** I have been informed of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

**Signature** _____ **DOB:** _____ **Date:** _____

**Acknowledgement of Review of Financial Policy and Consent to Treat:** I have received a copy of this office's Financial Policy. Once I have signed this acknowledgement, I agree to all the terms and conditions contained therein and the agreement will be in full force and effect.

**Signature** _____ **DOB:** _____ **Date:** _____