North Georgia Pain Clinic

PAIN MANAGEMENT SPECIALIST

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If we participate with your insurer we will abide by our contract with them in terms of the fee schedule and write offs required. You are responsible for any copays, coinsurance or deductibles. Payment is due at the time of service. Failure to provide correct insurance information*, in a timely manner, will result in you being responsible for our fees, in full.

Check Policy: We do NOT accept checks on your initial office visit. We will accept cash, MasterCard or Visa. We do not take 3rd Party checks.

Referrals: Should any services we provide, such as office visit or urine drug screens, require a PCP referral, it is your responsibility to obtain this. Your failure to obtain this means you will be responsible for payment for services rendered.

Authorizations: If your insurer requires authorization for procedures and/or injections we will obtain these, if possible. However, these do take time and we need at least two week notice in order to do so. If you insist on having a procedure without an authorization you will be required to make payment at time of service for the procedure. Some insurers limit the number of certain procedures during a calendar year. If you feel that you require one after this limit has been reached you may schedule one once payment, in full, has been made.

Bad Checks: A $30.00 NSF fee plus a $5.00 Certified Mail charge will be incurred for all returned checks. Returned checks and fees must be paid in cash or by certified funds. Stopped payment on checks are grounds for discharge. After the second (2nd) returned check you will be on a **CASH ONLY.**

ASSIGNMENT AND RELEASE STATEMENT

By signing below, I understand the billing practices for North Georgia Pain Clinic, PC. I authorize payment of medical benefits to the North Georgia Pain Clinic and authorize them to release any medical information necessary to process claims. I understand that I am financially responsible for any copay, coinsurance, deductibles, non-referred and non-covered services as outlined in my health plan.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

*Under Georgia Law it is considered "Theft of Services" to obtain care by providing false insurance information.