NORTH GEORGIA PAIN CLINIC, PC

FINANCIAL DISCLOSURE STATEMENT

PATIENT NAME: ______________________________________

DOB: ________________

Your insurance company will send you an Explanation of Benefits (EOB) that will explain how the insurance company paid for your visit. It will also explain any amount for which you may be responsible.
Some insurance plans require you to pay different out-of-pocket amounts based on the type of service, surgical vs. office visits. Deductibles may also apply according to your insurance plan. You must provide the correct information prior to the office visit. Failure to provide the correct information prior to the office visit may result in you being responsible the balance due in full. By law, you will be responsible for any co-pays, co-insurance, deductibles, and non-covered services as outlined in your health plan. North Georgia Pain Clinic collects all payments due at time of service. Additional payment may be required per your insurance plan. **You are responsible for knowing your co-insurance, co-pay, deductibles, and non-covered services as outlined in your health plan.**

CHECK POLICY

- A $30 NSF fee plus a $5 Certified Mail charge will be incurred for all returned checks
- We do **NOT** accept checks on your initial office visit
- You will be on a **CASH ONLY** basis after the second (2nd) returned check
- Returned checks and fees must be paid in cash or by certified funds

ASSIGNMENT AND RELEASE STATEMENT

By signing below, I understand the billing practices for North Georgia Pain Clinic, PC and that I may receive multiple bills related to my office visit as explained above. 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 co-pay, co-insurance, deductibles, and non-covered services as outlined in my health plan.

Patient Signature: ______________________________________ Date: ________________