North Georgia Pain Clinic

FINANCIAL AGREEMENT

If we participate with your insurer, we will abide by our contract with them in terms of the fee schedule and write-offs required. 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. Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company.

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. **Bad Checks**: A $35.00 NSF will be incurred for all returned checks. Returned checks and fees must be paid in cash or by certified funds. Stopped payment on checks is grounds for discharge. After the second (2nd) returned check you will be **CASH ONLY.**

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. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. Prior authorization is NOT a GUARANTEE OF PAYMENT.

I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denied payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does not make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies

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: _____

Witnessed: _____ Date: _____

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