Patient Financial Responsibility Policy

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

- **INSURANCE COVERAGE** - Your insurance policy is a contract between you and your insurance. As a courtesy, we will file your claim. However, the patient is required to provide us with the most correct and updated information about their insurance and will be held responsible for any charges incurred if the information provided is not correct or updated.

- **APPOINTMENTS** – 24 hours' notice must be provided in the event you cannot keep an appointment. Should you not provide this notice; a cancellation fee of $25 may be added to your account.

- **NO SHOW** - If you fail to show for a scheduled procedure three (3) times, you may be charged a $100.00 'No Show' fee. If you cancel any procedure within 24 hours, you may be charged a $50.00 'Late Cancel' fee.

- **SSD/STD/LTD –** IPW DOES NOT fill out Social Security Disability, Short-Term or Long-Term Disability paperwork. FMLA paperwork will only be completed after you have been an established patient with us for six (6) or more months.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If your plan requires a referral and you do not obtain one, you will be held responsible for the visit charges in full at the time of service.

- **PRIOR AUTHORIZATION** – It is the responsibility of the patient to contact his/her insurance company and/or pharmacy, to provide prior authorization paperwork to IPW as required by your insurance company. Please allow 4-7 business days for medication prior authorization paperwork to be completed and for your insurance company response.

- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. We accept Cash, Visa, MasterCard, Discover, and American Express only. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of $20 may be added to your account.

- **OUT OF NETWORK PLANS** – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days; you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.

  ***Private Insurance Authorization for Assignment of Benefits/Information Release**: I, the undersigned, authorize payment of medical benefits to Innovative Pain and Wellness for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.*

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless financial arrangements have been made prior to your visit. We accept Cash, Visa, MasterCard, Discover, and American Express only.

- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for their deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

  ***Medicare Lifetime Signature on File**: I request that payment of authorized Medicare benefits be made on my behalf to Innovative Pain and Wellness for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.*

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment, you will be additionally held responsible for whatever charges we incur because of this need.

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