MISSION
advanced pain management & spine center

CLAIMS, PAYMENT, REVIEWS AND FINANCIAL RESPONSIBILITIES

Thank you for choosing **Mission Advanced Pain Management & Spine Center** as your health care provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Please understand that payment of your bill is essential in order to be able to provide our services. The following is a statement of our claims, payment and review policies which we require you to read and sign prior to any treatment.

Full payment for professional services is due at the time of service. Currently we only accept Checks.

Our practice participates with most insurance carriers. As a courtesy, we will contact your carrier to confirm coverage and estimate their payment for services rendered.

_____I agree to provide information regarding health insurance, workers' compensation, automobile, and other health care benefits which the patient may be entitled. Patient assigns payment(s), if any, from insurance carriers(s)/health benefit(s) plan to Mission Advanced Pain Management & Spine Centers for services rendered. The direct payment assigned and authorized includes any medical insurance benefits entitled, including any Major Medical benefits otherwise payable to patient under the terms of the policy, but not to exceed the balance due for services rendered.

_____I understand that if my insurance company or health maintenance organization does not consider the services received as covered/necessary or has not authorized the services, and I still elected to proceed with the service I will be fully responsible for the expenses of the service provided. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay larger co-pay, co-insurance or other charges. In the event that the insurance does not reimburse these services provided, I acknowledge that I will be responsible for any balance that it declines to pay for such services.

_____I understand that my appointment might be scheduled at a facility (Hospital or Ambulatory Surgery Center), and I will receive bills for services rendered by the facility separate and apart from the physicians's charges.

_____I understand that if I have an HMO with POS option and wish to use my PPO benefits without using HMO benefits, I cannot switch once treatment has been initiated.

We require you to make your payment at time of service. Prompt payment allows us to control costs which ultimately keep our fees to a minimum. Patients with a standard co-payment are required to pay this at the time of service. Patients whose co-insurance is based upon a percentage of the charge are required to pay an estimated percentage of their bill at the time of service. This payment will be applied toward your ultimate responsibility. If you have a deductible that has not been met, your insurance carrier will apply services to that deductible. We require you to pay your deductible at the time of service.

If you have insurance coverage, we are glad to help you receive maximum allowable benefits and will file your claim(s) for you. If your insurance carrier fails to process your claim within 45 days from the date of service, the balance becomes your responsibility. If an insurance problem occurs, you are asked to assist us in contacting your insurance carrier.

Please be aware that few insurance companies attempt to cover all medical costs. Some companies pay fixed allowances for each procedure/service while others pay only a percentage of the costs. Our practice is committed to providing the best treatment to you, and we charge what is usual and customary for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates which may bear no relationship to the current standard and cost of care in this area.

As required by your insurance carrier, you are responsible for obtaining any necessary referral if your insurance policy mandates such paperwork. You will need to present a completed referral at the time of your appointment. As required by insurance mandates you are also responsible to obtain the appropriate authorizations for medical treatment.

In the event that you are seen (by your acknowledgement) without the proper referral/authorization as required by your insurance carrier, you will be responsible for payment of all fees at the time of service. We will file a claim with your insurance carrier and reimburse you if they issue payment to us. We ask that you participate in any dispute with your insurance carrier regarding your policy guidelines and regulations.

NOTICE TO TRICARE BENEFICIARIES

If you are a TRICARE beneficiary, the prior two paragraphs do not apply to you. When you visit one of our physicians or physician's assistants, please identify yourself as a **TRICARE** beneficiary. If the services to be rendered to you are excluded from your **TRICARE** benefits, your payment options for these excluded services will be discussed with you at the time of your visit. If the services to be rendered to you are covered as **TRICARE** benefits, your only charge will be the applicable deductible, copayment and/or cost-sharing amount.

I authorize release of information, including financial information and confidential health information and medical records for services rendered regarding my injury or any other services, which may include records related to treatment for substance abuse, to my insurance carrier(s), managed care plan or other pay or, including past or present employer(s), authorized private review entities or entities acting on their behalf, authorized chart reviewers, the billing agents, collection agents, our attorneys or insurance companies, the Social Security administration, the Health Care Financing Administration, the Peer Review Organization acting on behalf of the federal govern-ment, and/or any other federal or state agency for the purpose of satisfying billed charg-es and/or facilitating utilization review and/or otherwise complying obligations of state or federal law.

There is a $75 charge for No Show or Call to Cancel clinic appointments with less than a 48 business hours notice.

Returned checks will be processed with a service charge of $35. Outstanding patient balances over 30 days will accrue a monthly 1.5% interest charge. Balances referred to collection services are subject to additional fees. In addition, patients whose accounts have been referred to collection agencies must pay any outstanding balance and pay for each visit in full at the time of the appointment before additional services/care will be provided.

Our staff is available to answer questions relating to how your claim was filed or any additional information the carrier may need to process your claim. However, coverage issues are best addressed by your employer or group plan administrator. Your insurance policy is a contract between you and your insurance carrier. Mission Advanced Pain Management & Spine Center is not a party to that contract and cannot act as a media-tor with the carrier or your employer.

In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorney's fees and other collection costs.

Disclosure of Financial Relationships: Mission Advanced Pain Management & Spine Center have NO financial interests or financial relationships with any vendor, lab or pharmaceutical company of any kind, your best interest is our ultimate priority and goal.

All patients have a right to choose where and from whom they receive health care services. If you would prefer to use other health care provider for laboratory, durable medical equipment or otherwise, please let our staff know. We can recommend other health care providers and/or work with your preferred health care providers.

Our practice believes that a good provider-patient relationship is based upon effective communications. If you have any questions, please feel welcome to call (949) 441- 5445.

By signing below I certify that I have read and understand the Claims, Payment, and Reviews Policy, have had the opportunity to ask questions and have them answered and accept the above conditions and terms. I further certify that I am the patient or guardian, duly authorized representative, parent or other family member of the patient.

Patient Name: _____

Signature of Patient or Responsible Party: _____ Date : _____

Witnessed By: _____ Date : _____
MAPMSC Representative