FINANCIAL RESPONSIBILITY

We ask that you read and sign this form to acknowledge your understanding of and agree to our patient financial policies.

INSURANCE COVERAGE

- It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by your insurance carrier.
- We attempt to verify that your coverage is valid at the time of your visit, and service is covered by your insurance. However, if your coverage is not in effect at the time of your visit, the financial responsibility for payment is yours.
- SPCC uses outside laboratories for urines, blood work, etc. It is your responsibility to know if your insurance participates with these laboratories.

INSURANCE CHANGES:

- If you have had any changes in your insurance coverage - even if there is only a small change in the co-payment amount or a change in the expiration date of the policy - you must notify us. Even a small discrepancy on the change form can lead to a claim denial.

CO-PAYMENTS, CO-INSURANCE AND DEDUCTIONS:

- Co-pays are due at the time of visit.
- Deductibles are patient's responsibility. The deductible is determined by the contract/coverage you have with your insurance carrier.
- You will be responsible for a $30.00 service fee if your check is returned for non-payment by the bank. In this event, checks will no longer be excepted for payment. Full amount of returned check plus $30.00 service fee will be required to be paid in full in order to be seen for appointment.

INSURANCE REQUEST:

- You are responsible for responding to any request from the insurance company for further information. Not doing so will result in a claim denial and you will be responsible for payment.

INSURANCE PAYMENTS SENT TO YOU:

- If insurance payments are sent to you, you are responsible for forwarding them to our office with a copy of the explanation of Benefits (EOB) received.

COLLECTION ACCOUNTS:

- In the case your account is forwarded to a collection agency, you are responsible to pay reasonable attorney fees if applicable.

APPOINTMENT NO SHOW:

- You are allowed three (3) no shows. Each no show will result in a $50.00 fee which must be paid prior to your next appointment being rescheduled. After three (3) no shows, you will be discharged from our care.

You will be notified of any changes to the Financial Responsibility Policies. A new agreement will be presented at that time.

I have read, understand and agree to your financial responsibility policies as stated above.

_____ _____

Patient Name Printed Date of Birth

_____ _____

Patient Signature Date

NAME:_____

DOB:_____

ACKNOWLEDGEMENT AND AUTHORIZATION:

*****Please sign and date each item*****

I have read and understand the HIPAA/Privacy Policy for SHENANDOAH PAIN AND PALLIATIVE CARE CLINIC, LLC.

Signed:_____ Date:_____

I hereby assign my insurance benefits to be paid directly to the healthcare provider.

Signed:_____Date:_____

I authorize SHENANDOAH PAIN AND PALLIATIVE CARE CLINIC, LLC. To release medical information required to process my claim.

Signed:_____Date:_____

I have read and understand the Financial Policy for SHENANDOAH PAIN AND PALLIATIVE CARE CLINIC, LLC.

Signed:_____Date:_____

I authorize SHENANDOAH PAIN AND PALLIATIVE CARE CLINIC, LLC. To obtain/have access to my medication history.

Signed:_____ Date:_____

I authorize my provider's office to contact me by mobile phone.

Signed:_____ Date:_____