PATIENT FINANCIAL PAYMENT POLICY

The Patient Financial Payment Policy has been developed to help our patients understand their financial responsibilities related to their healthcare and to answer any questions regarding patient and insurance responsibility. If there are any questions regarding your health care benefits, you should contact your health plan with the phone number located on your insurance card. **You** are responsible to notify us of any changes to your health plan coverage.

We accept cash, check or credit card for any payments required below.

Copayments You are responsible to pay your designated copay at the time of service.

Deductible Plans You are responsible for any deductible or co-insurance associated with your health plan coverage at the time of service.

Non-participating Carriers You are responsible for full payment at the time of service. We will provide you with proper documentation for you to submit to your insurance carrier for reimbursement.

Self Pay Accounts/Un-insured You are responsible for full payment at the time of service.

Collection Process All past due accounts of 90 days or more, may be turned over to a collection agency. The additional fees associated with the collection agency will be the responsibility of the patient.

Workers Compensation You are responsible for providing the office with the necessary information at the time of service to submit the charges to your Workers Compensation carrier. If you do not provide the information, you will be responsible for the full payment.

No-Fault You are responsible for providing the office with the necessary information at the time of service to submit the charges to the No-Fault carrier and completing the appropriate assignment of benefits requirements. If you do not provide the information, you will be responsible for the full payment. Some No-Fault carriers have deductibles on medical charges for which the patient is responsible.

Missed Appointments If an appointment is missed or not cancelled within 24 business hours of the appointment, you will be charged **$50.00** for an office appointment, and **$75.00** for a procedure appointment. You are responsible for any charges for missed appointment fees. Your insurance carrier will not pay these missed appointment fees.

Returned Check Charges There will be a **$34.00** charge for each check returned to us.

Referrals If your insurance require referrals, it is your responsibility to make the office aware of this and verify that the referral is in place prior to the visit or you will be responsible for the visit.

If you have any questions on the Patient Financial Payment Policy, please ask to speak to the Practice Manager at 585-491-6130.

I _____ _____/_____/_____ have read, understand and agree to the above policy.

Patient Name Patient Date of Birth

_____ _____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered the Notice of Privacy Practices from Rochester Pain Solution.

Please Print Name _____

Date of Birth _____

Signature _____

Date _____

Patient Name _____

Date of Birth ____/____/____

Due to HIPAA regulations, I give permission to the staff and physicians at Rochester Pain Solution to discuss my care with the names below. I understand if the names are not listed, the staff and physicians will not be able to release my health information.

Name:	**Relationship:**	**Phone number:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

In case of emergency or when we cannot reach you by your listed phone number, you may contact:

_____	_____	_____

I understand I have the right to revoke this authorization at any time verbally or in writing.

This agreement will be reviewed annually with the office staff.

_____ ____/____/_____

Patient Name