ADVANCED INTERVENTIONAL PAIN CONSULTANTS
JAIME ROBLEDO M.D.
FINANCIAL AGREEMENT 2017

Thank you for trusting **Advanced Interventional Pain Consultants** to partner in your health care. This financial agreement should answer questions regarding patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have, and sign in the space provided. If required, you will be given a copy of this agreement for your records.

Insurance
Your insurance coverage is a contract between you and the insurance company, and it is your responsibility to know your insurance benefits. As a courtesy, we will bill both your primary and secondary insurance companies. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, you will be billed, and payment in full will be your responsibility and will be expected within 30 days of receipt of statement. **Initial____**

Medicare
We participate in Medicare program. You are responsible for your co-insurance, any deductibles that have not yet been met, and services that are identified as patient responsibility on your Medicare Explanation of Benefits. We strive to inform our Medicare patients of services that will not be covered. **Initial____**

Patient Responsibility for Payment
You are responsible for payment of any co-payment, co-insurance, deductible or service not covered by your insurance, handling, collection or attorney fees. If you do not have insurance, you are responsible for payment of all services. Co-payments are due at the time of your service (NO EXCEPTIONS). If you are unable to pay your copayment, your appointment will be rescheduled.
Patient over-due balances noted on your monthly statement are due within 30 days of receipt. We will bill appropriate insurance if all required information is provided. **Initial____**

Procedures
In order for us to obtain referrals and/or pre-authorizations for procedures, it is important that we have your current insurance information. Depending on individual policies, your procedure may not be a covered benefit. It is your responsibility to check for optimal coverage and policy limitations, and to obtain referrals as required by your insurance company. Please contact your insurance company with questions regarding your coverage. **Initial____**

Non-Payment
The doctor might deny services if you don't pay in full or make the payments of your plan. Failure to pay will result in your account being referred to a collection agency, which may affect your credit. **Initial____**

Payment Options

We understand that financial circumstances vary from patient to patient. If you are unable to pay your balance in full, you must call our business office at (281) 717-4902 to make a payment plan. The total amount could be divided in a maximum of two payments.

We do accept Visa, Mastercard, Discover, American Express or cash. No checks allowed. No exceptions.

We do accept payments over the phone. **Initial____**

Cancellation / No-Show Policy

Patients must cancel or reschedule appointments at least 24 hours in advance. No voice messages are allowed, except for Monday appointment. Failure to do this, even for same-day appointments, will result in a **No-Show fee**: $50.00 for a follow up visit, $100 for procedure, and $200 per trial. A credit card number will be required to charge no-show fees. This would be done at the end of the day of the missed appointment. No-show fees won't be refunded. No exceptions. **Initial____**

Credit or debit card #: _____

Exp. date: _____Code in the back:_____

*This card will be charged only if you don't comply with our cancellation policy.

Medical Records

The office will charge $25.00, if you need a physical copy of your medical records. That amount must be paid at the time of the request. In case that another medical office requests your medical records we will need a signed consent form from their office and will fax them without a cost. **Initial____**

Billing questions

If you have any question regarding your statement, you should contact dora@buenavistahealth.com

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I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection service. If it becomes necessary to send my account to a collection service, I agree to pay for all costs and expenses, including reasonable attorney fees. I authorize AIPC to charge my card, if I don't comply with the cancellation policy.

Printed Name: _____

Patient Signature: _____ Date: _____