ADVANCED INTERVENTIONAL
PAIN CONSULTANTS

FINANCIAL AGREEMENT 2022

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 verify both your primary and secondary insurance, before every visit. **Remember that the information provided by your insurance is an estimate of your benefits; you might have credits or balances during the year.**

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.

Cancellations / No-Show Policy

- Patients must cancel or reschedule appointments at least 24 hours in advance for follow up and trials.
- Patients must cancel or reschedule appointments at least 48 hours in advance for SCS or PNS trials.
- Failure to do this, even for same-day appointments, will result in a **$150.00 NO-SHOW FEE**.
- No voice messages are allowed, except for Monday appointments.
- A credit/debit 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.
- If you decide not to leave a credit/debit card number you are responsible to pay the no-show fee before we schedule your next visit.
- If credit/debit card is declined AN EXTRA **$25.00** fee will be charged on the next visit as long with the NO SHOW FEE.

***No more appointments will be made if a No-show fee is pending.**

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.

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.

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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.**

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.

Non-Payment: The clinic might deny services if balance is pending. Failure to pay will result in your account being referred to a collection agency, which may affect your credit.

Medical Records: The office will charge $35.00, 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.

Billing questions: Buena Vista Health LLC is an independent company who is in charge of billing. If you have any questions regarding your statement, you should contact Dora Diaz at (832) 930-7065 or send an email to **dora@buenavistahealth.com**

I **(name)** _____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 Advanced Interventional Pain Consultants to charge my card if I don't comply with the cancellation/No-show policy.

_____ _____

Signature of Patient or Legal Representative **Date**