ADVANCED PAIN MEDICINE ASSOCIATES
Wichita, Kansas • 316.942.4519
Providing Hope for Pain Sufferers

PATIENT FINANCIAL POLICY

Advanced Pain Medicine Associates is committed to providing you with the best possible care and will be happy to discuss questions regarding our policies, fees or your responsibilities at any time. A clear understanding of the "Patient Financial Policy" is important for the entire scope of your care.

All patients must complete our "Patient Financial Policy" before seeing a provider. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance, phone changes etc.).

INSURANCE: As a courtesy, we will file your insurance claims. We will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply factual information as necessary. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. Do not assume that you will not owe anything if you have more than one insurance policy.

REGARDING HMO'S, PPO'S AND MANAGED CARE PROGRAMS: It is your responsibility to obtain referral forms required by your particular insurance company. We will do our best to remind you when a referral is due, but ultimately you are required to keep track of the referrals on hand. If you present to the office without a current referral you will be asked to sign an advanced beneficiary form and you will be responsible for the bill or reschedule the appointment. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100% responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

CO-PAYS: You are expected to pay your co-pay prior to seeing your provider. If you are unable to pay, you will be required to reschedule your appointment. Refunds of co-pays will not be given.

REGARDING PATIENTS WITH NO INSURANCE (*SELF-PAY PATIENTS*): If you do not have coverage or have insurance that we do not participate in, you will be required to pay for your services prior to seeing the provider or reschedule your appointment.

REGARDING MEDICARE: Our providers all participate with Medicare. We will file all claims with your Medicare and your supplemental insurance, if applicable. If you do not have a supplemental insurance you will be responsible for the co-insurance and/or deductible amount following the processing of your claim.

REGARDING MEDICAID/PROJECT ACCESS: Our providers do not participate in any form of Kansas Medicaid, Kancare program or Project Access. (Above policy regarding patients with no insurance will apply.)

FORM COMPLETION: A charge of **$30.00** is due before the forms will be processed. (Disability, FMLA, Physician statements, etc.)

WORKERS COMPENSATION/AUTO LIABILITY: Our office requires authorization prior to the initial visit. Any Work Comp or MVA information will need to be provided **PRIOR** to you being seen. We will do our best to obtain the authorization prior to the visit. You are also required to provide us with Health Insurance coverage in case your workers' comp or auto denies the service. If you do not have health insurance you may be asked to pay for the service in advance. Any claims paid after we have received your payment will be refunded promptly.

CO-PAYS/CO-INSURANCE/DEDUCTIBLES/GUARANTOR RESPONSIBILITY: Our office requires payment in full for any balance not paid by insurance within three months from the date of service. If you are unable to pay your balance in full it is the patient's responsibility to make arrangements with our business office. If payment is not received, we will enlist a collection agency's help after three months of non-payment. Referral to a collection agency may result in financial dismissal from our practice.

RETURNED CHECKS: There is a **$30.00** returned check fee payable in cash or money order.

NO SHOW APPOINTMENTS: You are expected to show for the appointments made for us to adequately provide care. Failure to provide 24-hours notice that you will not be keeping your appointment may result in termination from the practice. I understand I may be charged for any appointments missed without giving 24-hours prior notice.

By signing this form I acknowledge that I have read this policy and understand the terms outlined above. Failure to comply with the financial policy of APMA may result in suspension of services or dismissal from the practice.

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Patient Name (please print) **Patient Signature** **Date**