KANSAS PAIN MANAGEMENT
10995 QUIVIRA ROAD, OVERLAND PARK, KS 66210
Phone: 913.339.9437 Fax: 913.339.9538

FINANCIAL POLICY

		PATIENT NAME	
TODAY'S DATE		DATE OF BIRTH	

1. All co-payments, co-insurance and deductibles must be paid at time of service as required by the terms of our contract with your health insurance provider. Please understand that failure on our part to collect these payments can be considered insurance fraud. For your convenience we accept MasterCard, Visa, Discover, and American Express, as well as cash and check payments.
_____* As of October 1st, 2018, Kansas Pain Management now requires a Credit/Debit card to be kept on file for any visits or treatments that REQUIRE CO-INSURANCE AND ARE NOT COVERED BY A FULLY INSURED PLAN (i.e. Medicare plus Medigap/Tricare/TriWest/VA/etc). IF YOU ARE A DUALLY INSURED PATIENT (have primary and secondary insurance coverage), ONLY THE POLICY ACKNOWLEDGEMENT APPLIES TO YOU. YOU ARE NOT REQUIRED TO HAVE A CARD ON FILE. In the event you have co-insurance, after your insurance claim has been processed and there is a balance due that is the patient's responsibility, you will be sent a statement to the address we have on file. If the balance is not paid within 30 days of your statement date and you have not contacted our office to make other arrangements, the card on file will be charged the outstanding balance. If the card on file is declined, you will be charged a $30 service fee. If it becomes necessary to turn your account over to a collection agency due to delinquency you agree to pay reasonable attorney fees or collection expenses incurred by Kansas Pain Management. All returned checks will be assessed a $30.00 returned check fee. IT IS YOUR RESPONSIBILITY TO UPDATE YOUR ADDRESS INFORMATION WITH OUR OFFICE.

2. Please keep in mind that your health insurance policy is a contract between you and your insurance company. As a courtesy to you, we will file your claim with your insurer if you agree to have payment made directly to our practice. If your insurance company does not provide payment within 90 days we may require payment from you. If we later receive a check from your insurer, we will refund any overpayment to you. IT IS YOUR RESPONSIBILITY TO UPDATE YOUR INSURANCE AND ADDRESS INFORMATION WITH OUR OFFICE.

3. Please be aware that some of the services you receive may not be covered or may be deemed not medically necessary by Medicare or other insurance companies. You will be responsible for payment of all charges for services not covered by your insurance company.

4. All patients must complete our patient registration forms before seeing the doctor. We must obtain a copy of your driver's license and insurance card EVERYTIME you see the physician. If you fail to provide us with correct insurance information in a timely manner, we will not reprocess the claim and you will be responsible for the full amount of a claim.

5. When you schedule an appointment, that time is reserved specifically for you. We kindly ask that you provide a minimum of 24 hours notice when cancelling an appointment. If you do not give adequate notice or fail to keep your scheduled appointment you may be charged a fee of $50.00.

By signing this form, I acknowledge I understand and agree to the above payment policy. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. This authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this form I am responsible for payment of services in full before services are rendered.

IF YOU CHOOSE <u>TO NOT LEAVE</u> YOUR CREDIT CARD INFORMATION ON FILE, YOUR CO-INSURANCE BALANCE WILL BE <u>DUE AT THE TIME OF SERVICE</u> AND ANY FUTURE APPOINTMENTS WILL NOT BE ALLOWED UNTIL PREVIOUS VISIT BALANCES ARE PAID

PATIENT PRINTED NAME

PATIENT SIGNATURE DATE

CREDIT CARD TYPE (Please CIRCLE) VISA MASTERCARD AMEX DISCOVER CREDIT CARD EXPIRATION (MM/YY)

CREDIT CARD # CVV (3 DIGIT # ON BACK OF CARD)

CARDHOLDER NAME

↓CARDHOLDER ADDRESS↓

CITY STATE ZIP CODE

CARDHOLDER SIGNATURE OFFICE STAFF INITIALS