Johnston Pain Management Insurance Information and Consent to File

FINANCIAL AGREEMENT

I, the undersigned patient, assign directly to Johnston Pain Management all benefits, otherwise payable to me for services rendered. I also authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic**. I acknowledge that payment is due at the time of treatment.** I accept full financial responsibility for all charges not covered by insurance. Certain tests may be ordered by the doctor(s) of Johnston Pain Management. I agree to be financially responsible for these services should they be considered "non-covered" or not medically indicated by my insurance company. A Pain Perception Test (PPT) is ordered on all new patients. This is comprised of a series of questions including demographical, medical, and psychological data. If my treatment is involved with a work related injury and JPM is to file Workman's Compensation claims on my behalf, I authorize the doctors and staff to discuss plan of treatment, care and appointment information with claims payers and/or case workers. If at any point during or after my treatment in the clinic I should desire a copy of my medical records, there will be a minimum fee of $12.00. After the first 20 pages there will be a fee of $0.50/page. Payment must be received in advance along with a HIPPA compliant release form and an original signature. Should I desire to have them mailed, I must provide Johnston Pain Management with a self-addressed stamped envelope. The preparation may take up to four weeks. For any form that Johnston Pain Management is asked and agrees to fill out, there will be a minimum fee of $25.00 payable prior to completion of the form. This fee will be billed directly to me and will not be filed with an insurance company or other third party.

APPOINTMENT NON-COMPLIANCE CONTRACT

Patients who no show or cancel with less than 24 hours notice of their scheduled appointment will be charged a $25.00 fee, for which the patient, not their insurance company is responsible. If a patient no shows or cancels with less than 24 hours of their scheduled appointment more than once, the patient will be charged a $50.00 fee for each additional infraction. Johnston Pain Management understands that not showing and late cancellations for appointments sometimes can not be helped. As soon as you are aware that you will be unable to keep your appointment, please notify the office immediately. This fee must be paid in full before Johnston Pain Management will allow me to reschedule any type of appointment. A late fee of $15.00 will be added to your account, if the balance is not paid within 60 days.

Appointment times are given as estimated times that patients will be seen by the doctor. I understand the length of the office visits are based on the needs of each individual patient in the clinic and that there may be minimal or extended delays.

PLEASE NOTE

THE FIRST VISIT WITH OUR OFFICE WILL TAKE 2 TO 4 HOURS. IF YOU DO NOT HAVE THIS MUCH TIME YOU MAY WANT TO RESCHEDULE YOUR APPOINTMENT.

Primary Insurance:______________________________

Policy Holder Name:______________________ Policy Holder Date of Birth:_____/_____/_____

Member ID#:______________________ Group #:______________________

Secondary Insurance:______________________________

Policy Holder Name:______________________ Policy Holder Date of Birth:_____/_____/_____

Member ID#:______________________ Group #:______________________

Tertiary Insurance:______________________________

Policy Holder Name:______________________ Policy Holder Date of Birth:_____/_____/_____

Member ID#:______________________ Group #:______________________

I agree that the above information is true and correct to the best of my knowledge.

*****All patients are required to update and sign a financial agreement every year*****

Patient Signature:______________________________ **Date:**__________

Office Staff Only: Entered on:__________ Initials:__________ Copy of Photo ID & Insurance Card(s) obtained: YES/NO