

Thank you for choosing us as your pain provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you **are not insured**, a **pre-payment** in the amount of **$300** is required **for New Patients** and **$175 for Established Patients** before being seen. Any additional balance(s) will be billed to the patient. Over payments will be refunded. You must provide us with a copy of your insurance card(s) at the time of the visit. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of Identity** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver’s license or state issued ID. This helps in reducing identity theft.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us on your next visit so we can make the appropriate changes to help you receive your maximum benefits.
7. **Nonpayment.** If your account is over 120 days past due, you could receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Accounts must be in good standing and must remain under $1000 to be able to be seen by a pain provider or have a prescription refilled. If your account is past due your account will be flagged and payment arrangements will have to be made. Also, please be aware that if a balance remains unpaid, we may refer your account to a collection agency. This collections balance must be paid prior to being scheduled or a prescription being refilled. If your account is sent to collections more than two times, there is a possibility that you may be discharged from the practice.
8. **Billing:**
9. **West Lakes Surgery Center.** *Patients will be receiving* ***two separate statements*** *for services rendered at West Lakes Surgery Center. Patients will receive a statement from***Medical Center Anesthesiologist and Pain Specialist of Iowa** *for* ***physician services.*** *Patients will also receive a statement from* ***West Lakes Surgery Center,*** *which will include charges for the use of the room, supplies or equipment during the visit*.
10. **MercyOne Pain Center and Mercy North Ankeny**. *MercyOne Pain Center and Mercy North Ankeny are considered an* ***OUTPATIENT HOSPITAL VISIT,*** *not a standard office visit. This means the facility (MercyOne) will bill your insurance for charges for the use of the room, supplies/equipment. Medical Center Anesthesiologists and Pain Specialists of Iowa will bill your insurance for the provider services. These charges will be processed through the* Outpatient benefits *of your insurance plan, meaning* ***higher out of pocket expense*** *due to deductible and co-insurance. You could then receive a statement from MercyOne for the facility fee AND a statement from Medical Center Anesthesiologists and Pain Specialists of Iowa for the provider fees.*

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

**CANCELLATION / “NO SHOW” POLICY**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.

**A $50 NO SHOW FEE WILL BE BILLED ON ALL FAILED APPOINTMENTS OR CANCELLATIONS WITHOUT 24 HOUR NOTICE. THE NO-SHOW FEE MUST BE PAID PRIOR TO RESCHEDULING.**

1. If an appointment is not canceled at least 24hrs in advance you will be considered a “no-show”. A $50 fee will be assessed to the patient and will need to be paid before scheduling any future appointments.
2. If two appointments are “no-showed”, a $50 fee will be applied, a warning phone call will be made to the patient, and a warning letter sent stating if patient no-shows again, they could face termination from the practice.
3. If three appointments are “no-showed” in a twelve month time period, no further appointments will be scheduled with any provider and your referring physician will be notified.

I acknowledge that I have read and understand the Payment Policy above information. I am also aware I may be charged if I fail to show up for my appointment or to give 24 hour notice of canceling my appointment.

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Printed Name

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Signature Date