Kansas PAIN MANAGEMENT

10995 QUIVIRA ROAD, OVERLAND PARK, KS 66210

Phone: 913.339.9437 Fax: 913.339.9538

Financial Policy

You are financially responsible for the medical services you receive. Please review our policies below and sign at the end to indicate your agreement to these terms.

Copayments for clinic visits are due at the time of service. If you are unable to make your copayment at the time of service, Kansas Pain Management reserves the right to reschedule your appointment until a time that you can make your copayment. Payment for any outstanding balance(s) is due at your appointment.

Procedure Prepayment. Kansas Pain Management collects your anticipated patient responsibility for a procedure at the time when the procedure is scheduled. Your prepayment is based on an estimate of your expected financial responsibility. **This is an estimate only.** While we attempt to provide accurate estimates, the terms of your insurance plan and how your insurance processes the claim may result in a different amount owed by you. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of an overpayment you may request a refund according to our refund policy, below. We reserve the right to reschedule your procedure until prepayment has been made.

Missed Appointments and Late Arrivals. If you are more than 15 minutes late, we may reschedule your appointment. If you are more than 60 minutes late, or If you do not cancel your appointment prior to, or within 15 minutes after your scheduled appointment you will be responsible for a missed appointment fee. Missed office visit appointments are subject to a $25 charge. Missed procedure appointments are subject to a $58 charge. These charges are your responsibility and cannot be billed to any insurance carrier.

INSURANCE PAYMENTS

Financial Responsibility. Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier or health plan.

Coverage Changes and Timely Submission. It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which Kansas Pain Management must submit a claim on your behalf to your insurer. If Kansas Pain Management is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you may be responsible for the charges.

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Self-Pay. If you do not have health insurance, or if your health insurance will not pay for services rendered by Kansas Pain Management, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available from our front desks). Self-pay patients are expected to make payment in full at the time of service. **PLEASE SEE OUR POLICY FOR ACCOUNT BALANCES AND PAYMENTS.*

BENEFITS AND AUTHORIZATION

Insurance Plan Participation. We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned provider participates in your plan. If we are out of network with your health plan, you may have higher deductibles and copayments for our services.

Referrals. Referral and prior authorization requirements vary widely among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by Kansas Pain Management, it is your responsibility to be aware of this fact, and to obtain this referral.

Prior Authorization and Non-Covered Services. Kansas Pain Management may provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. Kansas Pain Management, as a courtesy to our patients, makes a good faith effort to determine if services we order are covered by your insurance plan, and, if so, whether a prior authorization for treatment is required. If we determine that a prior authorization is required, we will attempt to obtain such authorization on your behalf.

Out of Network Payments. If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to Kansas Pain Management, immediately. Failure to do so could lead to you being sent to our Collection agency and termination as a patient from our practice.

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ACCOUNT BALANCES AND PAYMENTS

Credit Card on File **Kansas Pain Management now **requires** a Credit/Debit Card on file. In the event you incur a balance after your claim for treatment has processed and the balance becomes your responsibility, the credit card on file will be processed to satisfy your balance. If the card declines, you will incur a $30.00 service fee. If it becomes necessary to send your outstanding balance(s) to our Collection Agency, you agree to pay reasonable attorney fees or collection expenses incurred by Kansas Pain Management. All returned checks will be assessed a $35.00 return check fee, and you will no longer be able to make payment by check moving forward.

****IF YOU REFUSE TO ALLOW KANSAS PAIN MANAGEMENT TO KEEP A VALID CREDIT/DEBIT CARD ON FILE, YOUR ESTIMATED COST OF TREATMENT WILL BE DUE IN FULL AT TIME OF SERVICE.**

Refunds. Refunds for overpayment or prepayment on cancelled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Any overpayment will be applied to prior unpaid balances, and remaining funds will then be reimbursed to you.

Statements. Charges shown by statement are agreed to be correct and reasonable unless disputed within sixty (60) days of the billing dates. Statements are a courtesy and as the party receiving services, it is always your responsibility to keep your account in good standing. Failure to do so may lead to termination from Kansas Pain Management.

Agreement

I have read and understand the financial policy of Anesthesiology Professionals, and I agree to abide by its terms. I understand that I am financially responsible for all services I receive from Anesthesiology Professionals. This financial policy is binding upon you and your estate, executors and/or administrators, if Applicable.

Signed:_____ Date:_____

Credit card information

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Please choose one: Visa_____ Mastercard _____ Discover_____ Amex_____

Patients Name _____

Name printed on Card _____

Signature of card holder _____ **Date** _____

** By signing above, I agree that Kansas Pain Management is allowed to bill the above noted credit card for the amount of outstanding balances incurred for services received.