LEGACY PAIN ASSOCIATES
FINANCIAL POLICY
AUTHORIZATION/AGREEMENTS

The physicians and employees of Legacy Pain Associates are dedicated to providing you the best possible care. We regard your understanding of our office and financial policies an essential element of your care. Our intent is to be fair, transparent, caring and accessible. If you have any questions, please discuss them with one of our staff members.

Your signature below authorizes the following:

I do hereby acknowledge that I am the guarantor of this account and agree to pay for services rendered. I assign to Legacy Pain Associates (LPA) all insurance benefits or Medicare benefits to which it may be entitled for services rendered by its providers and authorize direct payment to the practice. I agree to pay the practice for all charges not paid pursuant to this assignment.

For ERISA, out-of-network and self-funded plans, I assign and convey directly to Legacy Pain Associates, as my designated authorized representative, all insurance reimbursement for services rendered by LPA regardless of network participation status. I authorize LPA and its authorized agents to negotiate, discuss, appeal and in any other way communicate with my insurance company to determine final payment for services I received. LPA has full authorization to accept or reject any reimbursement proposal and to act as necessary to accomplish the final adjudication of any claims, the result of which is binding upon me.

I hereby authorize Legacy Pain Associates to release any pertinent medical information to my insurance company(ies), including governmental health care insurers (such as Medicare) or other health care practitioners involved in my care. I understand that my treatment may be discussed with my referring physician or physicians I am being referred to. I am giving this authorization for release of information necessary for my continuity of care, to determine insurance benefits and for the payment of any claims.

I understand that insurance coverage and verification is not a guarantee of payment. I agree that I am ultimately responsible for any balance due after insurance has paid or denied my claim(s). I understand that I am responsible for any charges if the insurance company denies a claim for any reason including stating it is investigational, experimental, a pre-existing condition, auto-related or accident related where liability insurance is involved, or any other non-covered service(s).

Legacy Pain Associates utilizes physician assistants and nurse practitioners to assist in the delivery of medical care. I acknowledge that Texas licensed non-physician practitioners are not physicians and can, under the supervision of a physician, diagnose, treat and provide medical care. Supervision does not require the constant physical presence of a supervising physician, but rather overseeing and accepting responsibility for the medical care. I acknowledge this information and consent to the services of a non-physician practitioner for my health care needs.

I understand that in some cases my physician may refer me to an out-of-network provider and that I may have more out-of-pocket costs from such provider. I understand it is my responsibility to confirm whether or not the provider is in network with my plan

Responsibilities and acknowledgement of financial policy specifics:

I agree to present my insurance card and photo ID at each appointment and to share any changes in address, telephone number and/or insurance information updates any time a change occurs. I hereby agree that I am responsible for the payment of any co-payment, deductible and co-insurance and I agree to make payment for these amounts at the time of service. If I am not covered by insurance, I agree to pay for services rendered at the time of service unless other payment arrangements have been made in advance. We prefer major credit cards or checks. Returned checks for any reason will result in an additional charge.

Your insurance is an agreement between you and your insurance company. As a courtesy to you we will file your insurance claims for you if you assign benefits to the practice. If your insurance does not pay, we will look to you for payment of your balance in full.

All health plans are not the same and do not cover the same services. If your health plan determines a service to be "not covered" you will be responsible for the charges. Payment is due upon receipt of a statement from our office. You are responsible for knowing and understanding your insurance benefits.

You will be responsible for promptly responding to your insurance company to provide additional information they may request regarding your treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in your account becoming due and payable in full by you.

All HMO and some PPOs require prior authorization and/or referral from your primary care physician for each visit.
IF YOU DO NOT HAVE THIS REFERRAL NUMBER AT THE TIME OF YOUR APPOINTMENT, YOUR BENEFITS MAY BE PAID AT A REDUCED RATE OR NOT AT ALL AND YOU WILL BE RESPONSIBLE FOR THE CHARGES.

If it is necessary for you to cancel your scheduled appointment, please advise us at least **24 HOURS in advance for office appointments and 48 hours in advance of a scheduled procedure. If you miss multiple appointments without complying with the requested notice period, LPA reserves the right to charge a fee as posted in the office, including the option to terminate you from the practice**. **There will be a fee of $50 for No Show office appointments and a fee of $150 for No Show procedure appointments.**

I have read and understand the financial/office policy outlined above and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by LPA.

Patient Name:_____ Date of Birth: _____

Patient Signature _____ Date: _____

If patient is a minor (less than 18 years of age) or incapacitated:

Responsible Party Name: _____ Relation: _____