COLUMBUS PAIN CENTER, P. C.
PATIENT FINANCIAL POLICY

Please read carefully, initial each item, sign your name and the date you signed this form.

____ As a courtesy, we verify all insurance coverage possible prior to your first appointment at Columbus Pain Center. Your insurance coverage is a contract between you and the insurance company, and as such, you are responsible for obtaining necessary referrals and following plan guidelines and practices. If a referral is required for your policy and this is not received by our office at the time of your appointment, your appointment may have to be rescheduled. If, for any reason, your insurance coverage changes or additional insurance is obtained, we ask you to notify us as soon as possible. Failure to notify our office of insurance changes may result in you receiving the bills for all rendered services.

____ I hereby assign, transfer and convey payment and authorize said payment to be made directly to Columbus Pain Center, P. C. and/or Daniel H. Serrato, M. D. of any medical benefits for which I am entitled. I further agree that this assignment will not be withdrawn or voided at any time until this account is paid in full. I further understand I am responsible for any charges not covered by my insurance company.

____ I authorize Columbus Pain Center to release medical and supporting documentation compiled in my medical record to my insurance company and referring physician.

____ Co-Pays, deductibles and patient pay portions are collected at the check-in desk on the date of your appointment. As a courtesy, Columbus Pain Center will file your charges with your insurance company in a timely manner. With most insurance plans, there is a portion of fees that are the patient's responsibility and prompt payment of these fees is expected.

____ Balances that are found to be the patient's responsibility will be mailed to you in a detailed statement monthly. If no action is taken to pay your outstanding balances after sixty days, your account may be turned over to our collection agency.

____ Patients are seen on a scheduled appointment basis. We ask that you notify our office at least 24 hours in advance if you will be unable to keep your scheduled appointment. This allows other patients to be seen in a timely manner. Repeated failure to cancel an appointment may result in a charge for a no-show appointment.

____ It is understood and agreed that Columbus Pain Center is not liable for the loss or damage to any articles of personal property while on these premises.

Patient (Guarantor) Signature _____ Date _____

Witness Signature _____ Date _____