SPECIALTY PAIN MANAGEMENT CENTER

AJAY M. NARWANI M.D., PLLC

DIPLOMATE IN ANESTHESIA, AMERICAN BOARD OF ANESTHESIOLOGY
DIPLOMATE IN PAIN MEDICINE, AMERICAN BOARD OF ANESTHESIOLOGY

FINANCIAL AGREEMENT & CANCELLATION POLICY

PLEASE READ THE FOLLOWING AGREEMENT. IT EXPLAINS YOUR FINANCIAL OBLIGATIONS WHILE UNDER OUR CARE AND OUR POLICIES REGARDING CANCELLATIONS.

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT: I authorize treatment of the person named above and agree to pay all fees and charges for such treatment promptly upon presentation of statement, unless prior credit arrangements have been agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date. Although this office may assist me in filing an insurance claim, I understand that I am fully responsible for the balance and agree that payment will not be delayed because of any pending insurance claim. In the event, legal action should become necessary to collect an unpaid balance, I agree to pay all reasonable attorney's fees or other costs the court may determine proper.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION: I authorize all insurance benefits, unless previously paid by myself, to be paid directly to this physician/facility and also authorize the physician/facility to release any information required in the processing of the insurance claim. I authorize the physician/facility to release medical information to my referring physician, primary care physician, spouse, children, parents and any physician he/she may refer me to.

ALL MEDICARE PATIENTS MUST SIGN THE FOLLOWING STATEMENT: I request that payment under the medical insurance program be made on my behalf to Specialty Pain Management Center for any services furnished me by its physician(s) and/or practitioners. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Name: _____ Signature: _____

Insurance Benefits
Arizona State Law (HB2600) requires that medical claims be paid by insurance carriers within 90 days. If your insurance carrier has not appropriately paid the submitted claim within 90 days, I understand that outstanding balances will become the responsibility of the policy holder.

Insurance Co-Payments
In accordance with my insurance contract, I understand that co-payments are due at time of service.

Deductible
If my insurance deductible has not been met, I understand that outstanding deductible amounts will be collected at the time of service unless other payment arrangements have been made.

Co-insurance
I understand that co-insurance amounts may be collected at time of service, and at the time interventional procedures are scheduled.

Private Pay
If I have no insurance coverage, or insurance with which Specialty Pain Management does not participate, or Specialty Pain Management is unable to verify current insurance coverage, I understand full payment is expected at time of service. We do accept **SELF-PAY patients (i.e. Patients with *NO* insurance)**, Initial consultation is $400.00 that is due at the time of service. Follow up visits are $150.00 due at time of service, if a urinalysis is required it will be $200.00. If a procedure is scheduled- a fee schedule will be discussed with you prior to the appointment day. The amount discussed will be due at the time of service.

Notice to Medicare Patients:
If we are unable to verify from Medicare that there is automatic submission of claims to the secondary insurance carrier, you may be responsible for secondary insurance balances at the time of service and at the time interventional procedures are scheduled.

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Refund Policy
I understand that amounts collected from me (including co-payments, co-insurance and deductibles) are based on information received by Specialty Pain Management from my insurance carrier. Refunds are to be requested from your insurance company. Specialty Pain Management is not responsible for reimbursements.

Verification of Benefits and Non-Covered Services
Insurance policies are individualized per patient plan. Specialty Pain Management may provide services that my insurance plan excludes. I understand that it is my responsibility to verify coverage benefits and exclusions. I understand that all non-covered services are my responsibility.

Collections
I understand that once an account is placed in a collection status, all future services must be paid in full at time of service (no checks accepted). If my account is placed into collections, I will be responsible for all collection and interest costs.

Returned Checks
Returned checks will be subject to a $30.00 returned check fee.

NO SHOW, LATE CANCELLATIONS OR RESCHEDULING
Regretfully, we have been forced to institute this policy due to a large volume of last-minute cancellations, scheduling changes, and "no-shows."

- We have a very busy practice. Assuring that all our established patients have access to their doctor when necessary is a constant challenge. When you cancel or reschedule at the last minute, or fail to show for your appointment, you are depriving another patient the care they need. You must cancel or reschedule within 24 hours.
- New patient visits require our doctor to block out large time slots, making last minute cancellations and rescheduling of visits even more problematic. We provide a large amount of time and attention with each and every one of our new patients because we are committed to providing the highest quality care.

NEW PATIENT APPOINTMENTS:

- **IF YOU FAIL TO SHOW FOR YOUR APPOINTMENT, YOU WILL BE CHARGED $50.**

FOLLOW- UP VISITS:

- **IF YOU FAIL TO SHOW FOR YOUR APPOINTMENT WITHOUT NOTIFICATION YOU WILL BE CHARGED $35.**
- **IF YOU CONTINUE TO CANCEL, RESCHEDULE, OR FAIL TO SHOW FOR YOUR SCHEDULED APPOINTMENTS YOU WILL BE DISCHARGED FROM OUR PRACTICE**

PROCEDURE APPOINTMENTS:

- **IF YOU FAIL TO NO SHOW FOR YOUR PROCEDURE APPOINTMENT YOU WILL BE CHARGED $300.00,**

ADDITIONALLY, I ACKNOWLEDGE THAT IF I HAVE 2 OR MORE "NO SHOW" OR "LATE CANCELLATIONS" FOR ANY SERVICE, I MAY BE REFERRED FOR TREATMENT TO ANOTHER CLINIC.

Medical Records
We are happy to provide you with copies of your medical records upon request. However, because of time restrictions, please allow up to 30 business days to fulfill this request. Please note there is a charge for personal use, however, medical records sent to another medical provider will be done free of charge.

I HAVE READ AND AGREE TO ABIDE BY THIS FINANCIAL POLICY AND NOTICE OF PRIVACY PRACTICES. By signing this, you are indicating that you understand and agree to the terms of service explained above.

Name: _____ DOB: _____

Signature: _____ Date _____

3008 N. DOBSON RD., SUITE 2., CHANDLER, AZ 85224
PHONE: 1-480-496-2699 FAX:1.877.422.3184