



Pain Management & Treatment Center, S.C.

## Financial Policy and Assignment of Benefits

1. I understand that Pain Management & Treatment Center, S.C. (hereafter referred to as “provider”) and PMTC Surgery Center (hereafter referred to as “facility”) will be happy to submit my charges for services, provided they have complete insurance information. It is my responsibility to notify the provider/facility of any changes in my health care coverage. I have been encouraged to read my policy to be sure that I have a complete understanding of my benefits.
2. I am authorizing my insurance company (s) to issue payment directly to the provider/facility the applicable policy benefits otherwise payable to me. In the event that I should receive this payment and explanation of benefits from my insurance company; I agree to forward the check and copy of the explanation of benefits to the provider/facility within 10 days of receipt. I understand that the check and explanation are due to the provider/facility in order to credit my account.
3. I understand that I am financially responsible to the provider/facility for any charges not covered by health care benefits, including all applicable co-payments and deductibles. I am responsible for the entire bill or balance of the bill as determined by the provider/facility and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility.
4. I authorize the release of any medical or other information necessary to all of my insurance companies. I authorize the provider/facility to act as my agent to obtain payment from my insurance companies.
5. I authorize the provider/facility to act as my agent to help me obtain required pre-certification.
6. I understand that the provider/facility contracts with different managed care carriers. My carrier may require a referral from my primary care physician. It is my responsibility to ensure that the referrals are received in the office within five (5) days of my visit. The provider/facility can provide me with the expiration date of my referral, but will not be held responsible for assuming any charges if the referral expires.
7. I understand the provider/facility accepts assignment on charges for services provided to Medicare patients. If I have a secondary insurance carrier, the claim will be submitted to them for payment on my behalf.
8. I understand that co-payments are expected at the time of service.
9. I authorize the use of this form on all my insurance submissions. A photocopy of this authorization shall be considered as effective and valid as the original.

THIS AUTHORIZATION IS IN EFFECT UNTIL I CHOOSE TO REVOKE IT.

By signing below, I authorize I have read and fully understood the above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If you have questions regarding our policies, please contact our Patient Financial Services Department at (414) 354-0772.