Solutions Pain and Spine Doctors

3780 Holcomb Bridge Rd, Ste D-1
Peachtree Corners, GA 30092

www.solutionspainandspine.com
Phone: 470-641-6444 Fax: 770-343-7696

FINANCIAL POLICY

1. All co-payments, co-insurance and deductibles **must be paid at time of service** as required by the terms of our contract with your health insurance provider. Please understand that failure on our part to collect these payments can be considered insurance fraud. For your convenience we accept MasterCard, Visa, Discover, and American Express, as well as cash and check payments.
2. Please keep in mind that your health insurance policy is a contract between you and your insurance company. As a courtesy to you, we will file your claim with your insurer if you agree to have payment made directly to our practice. If your insurance company does not provide payment within 90 days we may require payment from you. If we later receive a check from your insurer, we will refund any overpayment to you.
3. Please be aware that some of the services you receive may not be covered or may be deemed not medically necessary by Medicare or other insurance companies. You will be responsible for payment of all charges for services not covered by your insurance company.
4. All patients must complete our patient registration forms before seeing the doctor. We must obtain a copy of your driver's license and insurance card. If you fail to provide us with correct insurance information in a timely manner, you may be responsible for the full amount of a claim.
5. When you schedule an appointment, that time is reserved specifically for you. We kindly ask that you provide a minimum of 24 hours notice when cancelling an appointment**. If you do not give adequate notice or fail to keep your scheduled appointment you may be charged a fee of $50.00.**
6. You will receive a billing statement from us for any balance that is owed. All amounts are due upon receipt of this statement. If it becomes necessary to turn your account over to a collection agency due to delinquency you agree to pay reasonable attorney fees or collection expenses incurred by. Solutions Pain and Spine Doctors. **All returned checks will be assessed a $30.00 returned check fee.**

By signing this form I acknowledge I understand and agree to the above payment policy. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. This authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this form I am responsible for payment of services in full before services are rendered.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Patient's Printed Name_____ **Patient's Signature**_____**Date**_____

***Legal Representative's Printed Name**_____**Legal Representative's Signature**_____ **Date**_____

*If representative, specify relationship to the patient*_____

**Note: Proof of legal authority may be required for legal representatives.*

*If signing as the legal representative, I represent to Dallas Pain Institute that I am the legal representative of the patient and agree to provide proof of legal representation, if requested. Should my legal authority terminate, I agree to provide written notification to Dallas Pain Institute.