PACIFIC PAIN MANAGEMENT

Patient Name:
Date of Birth:

Medical Consent and Financial Agreement

Medical Consent

- I agree to the health care services provided by Pacific Pain Management and request my health care provider(s) to provide any care they think is necessary and consistent with my instructions.
- I understand this care may include tests, examinations, image captures, medical and surgical treatment. I acknowledge that no guarantee has been made to me as to the results that may be obtained from this care and that I can refuse services at any time. I understand if special procedures or operations are needed my health care provider will discuss this with me and additional consent may be required.

Financial Agreement

- I agree to pay for any care or services I receive at Pacific Pain Management according to its rates and terms.
- I agree to provide a credit, debit, or health savings account card, which may be charged for any amounts I owe for services received, unless other arrangements have been agreed on between myself and Pacific Pain Management.
- I understand that Pacific Pain Management will try to bill my insurance and others who may pay for my care. If my insurance or other party does not pay, I understand I am responsible for my bill. I acknowledge that all charges may not be determined at point of service. If insurance payment is not received after 30 days of submission, the balance in full becomes my responsibility. I agree payment will not be delayed because of a pending insurance claim. Accounts are payable at time of billing.
- I understand that I am financially responsible for all services not covered by my insurance, which may include copayments, deductible, and coinsurance. Further, I understand all copayments are due at the time of service. If my insurance deductible has not been met, I understand that outstanding deductible amounts may be collected at the time of service and at the time interventional procedures are scheduled. Any coinsurance amounts may also be collected at the time of service and at the time interventional procedures are scheduled.
- I understand that Pacific Pain Management will file a claim with my secondary insurance as a courtesy, but I am fully responsible for all amounts left unpaid by my secondary insurance.
- I understand some services may not be covered by my insurance policy. Pacific Pain Management will attempt to assist me in verifying if services are covered by my plan, however if the insurance carrier denies my services as non-covered, I understand that I am financially responsible for the denied service. I understand that verification of benefits and covered services is not a guarantee of payment by the insurance carrier.
- I authorize payment from all insurance or health plan benefits to go directly to Pacific Pain Management.
- If I have no insurance coverage, or if Pacific Pain Management is unable to verify current insurance coverage, I understand full payment is expected at the time of service and at the time interventional procedures are scheduled.
- It is the policy of this office to bill your motor vehicle accident carrier until your Personal Injury Protection (PIP) is expired or exhausted, whichever one comes first. I understand once the PIP coverage is no longer available, the account will be switched to my private insurance and all balances will become my responsibility. Pacific Pain Management will not accept a letter of protection from your attorney in lieu of billing your medical insurance. If I do not have private insurance, I agree to pay for medical services with cash.
- Refunds will be paid as soon as complete insurance reimbursement for all medical services on the account has been received.
- If my account is sent to collections, I agree to be responsible for all related costs. I understand that once an account has been referred to an outside agency, no further appointments may be scheduled with a provider at Pacific Pain Management.
- In the event legal action should become necessary to collect an unpaid balance, I agree to pay all reasonable attorney's fee or other costs the courts may determine proper.
- I agree to pay a $25 fee for all appointments cancelled, rescheduled, or missed with less than 24 hour notice. Continued missed appointments interfere with your treatment and therefore non-compliance may result in being discharged from our clinic.
- I understand that a $25 fee will be added to my account for all personal checks returned for insufficient funds.
- I understand laboratory, radiology, or outpatient facility services may be needed and recommended to me. If I obtain these services, I understand that I have a choice of where I receive these services and may receive a separate bill from the laboratory, radiologist, imaging center, outpatient facility, or other provider.

Use of Patient Information

- I understand Pacific Pain Management may use and disclose health information about me for treatment, payment, and healthcare operation purposes.
- I understand more information about how Pacific Pain Management will use and disclose my medical information can be found in the Notice of Privacy Practices. Pacific Pain Management reserves the right to change the Notice of Privacy Practices and will provide me with an updated copy if substantial changes should occur.

Patient Consent and Acknowledgement

- I have read and fully understand the above information and agree that I have been provided with a copy of the Notice of Privacy Practices. I promise that all information that I have given is correct. I have read and I agree to the terms of this form. I promise that I am the patient, or otherwise authorized to execute this document, and accept its terms on behalf of the patient. I assume individually all financial responsibility by signing this form.

_____	_____	_____
Patient/Responsible Party Signature	Relationship to Patient	Date