COMPREHENSIVE PAIN
MANAGEMENT SPECIALISTS

9834 Genesee Ave Ste 411 La Jolla, CA 92037
15725 Pomerado Road, Ste 107 Poway, CA 92064

Patient Acceptance of Financial Responsibility

The practice of Comprehensive Pain Management Specialists will bill your insurance company as a courtesy. However, you are ultimately responsible for all charges for services rendered. In the event that services rendered are not covered by your insurance company, we will require that you remit payment to CPMS Medical Group Inc. Additionally, if your insurance company does not remit payment in a timely manner (within 90 days from the time your claim is billed), we will transfer the balance to your responsibility and require that you remit payment to CPMS Medical Group Inc for all outstanding insurance balances over 90 days. The outstanding balances may include, but are not limited to:

- Office visit co-payments; Interest charges for overdue patient due balances; Annual deductibles; Administrative charges for co-payments not paid at the time of service; Services that are not covered by your health plan

In addition, your insurance company may require an authorization or pre-certification for certain procedures, services, drugs and supplies that will be provided to you. As a courtesy, we will contact your insurance company for authorization for services. However, it is ultimately your responsibility to understand what your insurance policy covers and assure that you have authorization for services. We may request your assistance in following up on our authorization requests and delayed payments. Your assistance in contacting your insurance company will often facilitate a more timely approval of services, prevent delays in treatment, and expedite payment for your services.

We frequently experience difficulty with insurance plans in receiving timely payment. Our policy is that we will bill you primary and secondary policies. If we do not receive payment within 90 days of the date we bill your insurance, then we will transfer the balance to your responsibility and require that you remit payment to CPMS Medical Group Inc. To prevent this, we suggest that you stay in communication with your insurance company to assure they are paying for the services we render. Often, insurance companies are more responsive when they are contacted by their policy holders. In addition, should our billing office contact you for assistance in obtaining payment from your insurance company, your prompt response to their calls would be appreciated. PMG, our billing service, may be reached at 1-877-235-5048 and they will work with you in obtaining payment on your claims.

We require timely payment when you receive your monthly statements. Balances are due upon receipt of your statement. If you would like to use a credit card for payment of your balance, please provide the following information. You will be notified in advance of charges made to your credit or debit card.

Credit Card: MasterCard/Visa/Other: ______________________________
Exp Date: ______________________________
Card Number: ______________________________
Name on Credit Card: ______________________________

You will be charged a *"Missed Appointment"* charge of $25.00 for all appointments that you miss and fail to give at least 24 hours notice. If you need to cancel your appointment, please note who you spoke to when you called to cancel your appointment, including the date and time. Failure to remit payment for your missed appointments may cause a delay in your appointment scheduling.

You co-payment is required at the time you check-in for your appointment. If you fail to bring your co-payment and we must bill you for it, an administrative charge of $10.00 will be added to your bill.

All patient balances that are past due will accrue and interest charges of 5% of your outstanding patient-due balance.

I understand and agree that I (or the person financially responsible for me) am financially liable for all services rendered and will pay my outstanding balance within 10 days of receipt of my monthly statements. I also understand that if my insurance plan does not pay CPMS Medical Group Inc within 90 days of the services billed, the balance will be transferred to my responsibility and payment will be due at that time.

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Patient's Printed Name

____
Patient's Signature

____
Date

OR

____
Responsible Party's Printed Name

____
Responsible Party's Signature

____

Date