

**Pain Care Consultants PC
Thomas W Hanlon MD**

Patient Financial Obligation Agreement

Payment is Due at Time of Service

- We accept cash, checks, debit and credit cards. A \$30.00 fee will be charged for all checks which are returned due to insufficient fund.
- Insurance required co-payments are due at time of service. If you are unable to pay your co-payment at check out you may be assessed an additional service charge fee.
- All outstanding patient balance are due at time of service
- Your co-pay amount is subject to change depending on your insurance plan and/or any procedures that may be provided during your visit
- All outstanding balances must be paid **prior** to your next visit or you may not be scheduled until payment is made.
- **Overdue accounts that are sent to collections will be charged a collection service fee.**

Billing Process:

- We will bill your insurance company first. It is your responsibility to inform the receptionist if treatment is covered by a third party payer – auto insurance, workers compensation or liability insurance company rather than your health insurance. You are required to notify the office of all the information pertaining to the third party carrier before your visit.
- You are required to provide your personal health insurance information as a back up to the third party carrier. If we do not receive this information from you and we get a denial from your carrier you will be billed and held responsible for the bill.
- If you receive payment directly from your insurance carrier we expect to receive payment in full from you within 10 days of the receipt of payment. You will be held responsible for payment for any charges incurred.
- It is your responsibility to notify Pain Care Consultants of any changes in your health insurance.
- If your insurance company requires a referral you are responsible to have your primary care physician send a referral to our office prior to your visit. If you do not have a referral and one is required you will be charged for the visit. If you have questions regarding your eligibility or coverage you should call the number on the back of your insurance card.

It is your responsibly to notify this office of any change in address, phone, or insurance coverage. We reserve the right to report delinquent account to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient to our practice.

You may contact our office Monday thru Friday 8:30AM to 4:30PM at (570)501-6860 to discuss payment options. We may require all co-pays to be paid before payment arrangements will be made on other outstanding balances.

If you are unable to keep you appointment you must cancel at least 24 hours in advance or you may be responsible for a \$25.00 no show fee.

PATIENT NAME: _____
I have received this statement and I am fully aware of my financial obligation.

PRINT NAME: _____

SIGNATURE; _____ **DATE:** _____

Authorization to Retain Credit Card account information for Payment

I, _____ hereby authorize Pain Care Consultants to confidentially retain and charge my credit card account for any outstanding medical bills.

Signature: _____ **Today's Date** _____

Credit Card Type: Visa ___ Mastercard ___ Discover ___

Credit Card Number: _____

Name on Card: _____ Expiration Date: _____

OFFICE USE ONLY

Information Verified by: _____ Date: _____