OKLAHOMA
PAIN CENTER

FINANCIAL POLICY

We at Oklahoma Pain Center are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive pain management care. Our fees reflect the complexity and resources involved in completing our services. In order to assist you with your health care investment and eliminate future complications we are providing the following payment policies.

Please carefully read and initial ALL of the categories regardless of your financial category.

Payment Options:

Cash/Check/Debit Card
Visa/Mastercard
Flex Card

Returned check Policy:

There is a $40.00 charge per returned check. We can only accept cash or cashier's check in exchange for a returned check. Partial payments are not accepted. Payment is required for the returned fee and check prior to any further visits. From the time a check is returned you may no longer pay your account by check. After a 10-day period, returned checks will be filed with the District Attorney's office for prosecution and this action cannot be rescinded.

Initials:_____

Private Pay:

For patients who do not have insurance, a down payment is required prior to the appointment. **The amount paid reflects the price of the office visit and cost of testing a urine specimen only. If any other procedures or actions are taken during the appointment, patients will be billed for the remaining cost.** We make every attempt to work with you and control our fees but please keep in mind that our charges are within the range of what is usual and customary for this area.

Initials:_____

Insurance Co-payments and Deductibles:

Your insurance is a contract between you and your insurance company. As a courtesy, we will submit appropriate insurance claims to your insurance carrier. However, the patient (responsible party) is responsible for all fees regardless of insurance coverage.

S. Blake Kelly, MD ● James Lynch, MD ● Jack Marshall, MD
Karie Stewart, APRN ● Stacy Torres, APRN ● Brandon Funk, PA-C ● Katherine Gaddis, APRN ● Jennifer McReynolds, PA-C
5101 W. Memorial ● Oklahoma City, OK 73142 ● Office (405) 752-9600 ● Fax (405) 752-9650
www.oklahomapaincenter.com

We are committed to providing the best treatment for our patients, however not all services are covered benefits in all contracts. Therefore, insured patients may have an account balance after the insurance company assigns benefits to us. In this event, we will notify you so you may satisfy the remaining balance. If you feel your insurance carrier has not paid correctly, please contact them instead of our office. We will not be able to provide you with any specific information regarding your particular insurance policy, nor can we change

any of your personal information with them. All co-payments will be collected at time of service and deductibles and co-insurance amounts are expected within 30 days of notice. Please be aware that copays, deductibles, and non covered services are set by your employer or insurance company.We allow 30 days for your insurance company to make payment. After this time, the balance becomes your responsibility to pay.

Accounts that are 90 days past due will be subject to collection action. Any legal activity would cause a breech in the physician/patient relationship resulting in discharge from the practice. If you have any questions or need clarification of the above listed policies, do not hesitate to contact our office.

Initials:_____

Motor Vehicle Accidents:

We see a very limited number of motor vehicle accident patients. These patients are seen by doctor referral only and must already have an attorney on record. Payment for these services will be filed with the appropriate insurance for the first 6 visits with a Lien being filed with the court. Upon the 7th visit you will be responsible for all charges incurred per visit at time of service.

Initials:_____

Workers Compensation:

Workers Compensation patients will be seen on a referral basis. All records and information must be obtained prior to initial visit. Insurance will be filed to the appropriate insurance company. Please keep in mind that we are unable to treat you for any health issues not specifically related your Workers Compensation claim as the insurance carrier for your claim will be rejected in its entirety.

Initials:_____

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No Show and Late Patients:

There will be a $75.00 charge for anyone that does not call, at least one business day prior to their appointment to cancel or reschedule. We understand that emergencies happen, but please keep in mind there is a difference between "An Emergency" and "Something Came Up." This charge is the patient's responsibility and will not be filed to insurance or applied to motor vehicle/workers compensation charges, and payment for this charge is required prior to next visit.

Initials:_____

Medical Records:

Each patient is entitled to one copy of their medical records at no charge. A request will need to be signed with the front desk and submitted. Medical records requested by insurance companies, Social Security and attorneys will be mailed to them with an invoice for the copy charges.

Medical Records obtained by other facilities will not be copied and included unless we order the testing.

Initials:_____

Delinquent Accounts:

All balances regardless of insurance benefits are considered delinquent 60 days after date of services rendered.

Initials:_____

I HAVE READ AND RECEIVED A COPY OF THIS AGREEMENT

_____ _____

Patient Name (Print) **Date of Birth**

_____ _____

Signature **Date**

We are happy to accommodate you in planning the most appropriate financial arrangement. We appreciate the trust and confidence you have placed in us for your health care and that you agree to this financial policy. You may speak with the Billing Supervisor or Office Manager.

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ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to Oklahoma Pain Center, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by Oklahoma Pain Center, regardless of its managed care network participation status. I understand I am financially responsible for all charges regardless of any application insurance or benefit payments. I hereby authorized Oklahoma Pain Center to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to Oklahoma Pain Center any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care facility or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to Oklahoma Pain Center any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I received from Oklahoma Pain Center (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the Oklahoma Pain Center all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by the above-named health care facility, including arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative Oklahoma Pain Center is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose an action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Oklahoma Pain Center as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____ _____

Patient Name (Print) Date of Birth

_____ _____

Signature Date

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