ADVANCED PAIN AND ANESTHESIA SERVICES

PEAK ANESTHESIA AND PAIN MANAGEMENT

Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between Advanced Pain and Anesthesia Services/ Peak Anesthesia and Pain Management (the provider of medical services) and the Patient who is receiving medical services, or Responsible Party for minor patients (those patients under the age of 18). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of services.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as The Responsible Party must:

- Inform use of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any required copay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. *(When we receive an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).*

Returned Check Policy

If a payment is made on an account by check and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or Patients Responsible Party will be responsible for the original check amount in addition to a $25.00 Service Charge.

Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the Patients Responsible Party, understands that APAS has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the Patients Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and collection fee will be added to the outstanding balance. By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patients Name(Print)____

Patients Signature____________________________ Date________________

Responsible Party Name(Print)____________________________________

Responsible Party Signature____________________________ Date________________