BENEFIT ASSIGNMENT POLICY

Given the constant changes to insurance company payment policies, the following in-office policies have been established to help us continue to provide the patient with the best quality of medical care. These policies are intended to assist the patient in receiving care and for greater understanding in all aspects of patient care. If you would like to discuss these office policies, please ask to speak with a member of our Billing Department.

PAYMENT IS DUE AT THE TIME OF SERVICE.
This includes co-pays, deductibles, co-insurance and non-covered charges.

a) Co-pay must be paid at the time of visit.
b) For the patient's convenience, the office accepts cash, Visa, Mastercard, Discover, and American Express
NO CHECKS ACCEPTED
c) The patient is responsible for ALL NON-COVERED SERVICE CHARGED
d) SELF PAY patients must pay at time of visit-

ESTABLISHED PATIENT- Subsequent visit fees-$100.00, Lab Test Fees-$127.00 Expected at next appointment
NEW PATIENT- $274.00 This includes the office visit fee of $147.00 and Lab Test Fee of $127.00

ANY CHANGES to your DEMOGRAPHICS or INSURANCE must be brought to our attention. BEFORE the Doctor's visit. Failure to do so may result in the patient being responsible in FULL for ANY & ALL charges for services rendered. The CORRECT information is CRITICAL especially for proper billing of laboratory tests that may be required and ordered. If this information is incorrect or not current the patient will be responsible for the bill in its entirety.
Health Insurance/Plan ID cards must be current.

If you have medical insurance, as a courtesy to you we will try to speed up the processing of your claim by submitting claims to your insurance company. However, your insurance plan is contract between you and your insurance company. Our office CANNOT guarantee that your carrier will pay your claim, If your claim is denied by your carrier, the obligation for payment is the responsibility of the patient. Our office will not enter into a dispute with the insurance carrier over the claim. We will however, be happy to assist wherever possible. If the patients' bill remains overdue greater than 90 days the following procedure will occur.

- Any outstanding balance after 90 days of the date of service will become Zero balance status and cannot carry a balance.
- All outstanding bills must be settled PRIOR to receiving future care, unless PRIOR arrangements have been made.

Precertification for procedures: Benefits verification/ Authorization contains general reimbursement information based on medical necessity and is not a guarantee of payment by my insurance company and is provided to me by PSGC- By signing this form, I am fully responsible for any balance due to non-payment by my Insurance company.

Cancellations/Missed appointments- Failure to keep your appointment or failure to cancel your appointment within a 24-hour notice to fill the time slot we have reserved for you will result in a penalty charge of $50.00 for an office visit and $150.00 for procedures. These fees are NOT covered by insurance and is sole responsibility of the patient. You the patient will be billed and payment is expected before next appointment. Please have the courtesy and respect to call our office for all appointments that cannot be kept. We work with you at every opportunity to provide you with the best quality health care.

I have read and understand the payment policy and agree to abide by its guidelines:

Print Name: ______________________________ Date: ______________

Signature: ______________________________

VERIFIED BY: PSGC EMPLOYEE NAME: ______________________ Date: ______________

Patient ID: __________

Authorization for Release of Confidential Health Information

Patient name: ______________________________ Telephone: ______________________

Address: __________________________________ Date of Birth: ____________________

City/State/Zip: ________________________________

I hereby authorize the protected health Information regarding the above-named person to be exchanged to the following person(s) listed below:

Person/Institution/Other: ____

Address: ____

City/State/Zip: ____

Phone #: ____

I authorize PSGC to release of information pertaining to the following time periods:

From date(s): ______________________ to date(s): ________________________________

I authorize PSGC to release information concerning my health information listed below: I authorize that my information may be released in the form of all methods checked below.

- o Telephone
- o With a person listed above
- o Mail to: office or home
- o Fax to: Home/Office, Fax number: ( ) ______________________

The following types of information to be disclosed are as follows:

- o Office Visit Notes
- o Operative Reports
- o History and Physical exam
- o Labs, X-rays, films
- o Picking up Records
- o Take messages concerning health information
- o Test Results
- o Insurance/Billing statements
- o Other: ____________________________

The following Highly Confidential items must be checked off to be included in the disclosure:

- o Behavioral or mental health information/records (740 ILCS 110/1 et seq)
- o HIV/AIDS related information/records (410 ILCS 305/9)
- o Drug/alcohol diagnosis, treatment, referral Information (20 ILCS 301/30.5; 42 CFR pt. 2)

- The release of information involving a direct or indirect payment to Pain Specialist of Greater Chicago S.C from a third party: for the sale of protected health information or for marketing.

The purpose(s) of this authorization is (are): ____________________

This authorization expires (date): ____________ **if not specified this release will expire 1 year after the date of signature**________________.

- I understand that I have the right to inspect and copy the information that I have authorized to be disclosed by this authorization. In the event that I refuse to authorize the release of the above-described information, I understand it will not be disclosed except as provided by law.
- I understand that the practice may not condition on whether I sign this authorization, except when the provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
- I understand that this authorization is valid until expires, unless revoked before that.
- I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. I have been provided a copy of the PSGC Notice of Privacy Practices. By my signature, I knowingly and voluntarily authorize Pain Specialist of Greater Chicago S.C to use of disclose my health information in the manner described above.

Please Contact our office immediately to make any changes to your HIPAA Form.

Printed name of patient, legal guardian, or authorized agent: ____________________

Signature of patient or legal guardian, or authorized agent: ____________________

Date: ____________________ Relationship to the patient: ____________________

Staff Initials: ____________________ Date: ____________________

Pain Specialist of Greater Chicago S.C

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