Carolinas Pain Institute
145 Kimel Park Drive, Suite 330
Winston-Salem, NC 27103
Phone: 336-765-6181 Fax: 336-765-8492
Website: www.carolinaspaininstitute.com

Financial Policy

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement showing the previous balance, new charges, finance charges, if any, payments and adjustments applied to your account.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month. Our office handles billing and they may be contacted at 336-765-6181.

Contracted Insurance: If we are contracted with your insurance company, we must follow the terms of that contract. If you have a co-payment, you must pay that at the time of service. The insurance company makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, we will assist you, BUT you are ultimately responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment or denial from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, It is the insurance company that makes the final payment determination. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, we will assist you, BUT you are ultimately responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment or denial from the insurance company.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these. Anyone not paying their co-payment will have their appointment rescheduled to another date.

Self-pay patients must pay $250 plus $65.00 for a urine drug screen which will be performed at your New Patient Visit, or $150 for Return Visits and if your provider feels that another urine drug screen is warranted you will be billed $65.00.

Returned checks: There is a $35 fee for any checks returned by the bank. Once a check has been returned for non-sufficient funds the returned check fee and amount of the check that was returned must be paid in full before another appointment will be scheduled. In addition, we will no longer accept checks and payment must be paid in cash or by credit card.

Missed appointment fee: Patients who miss an appointment or cancel an appointment with less than 24 hours' notice will be charged a $25 fee. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor. If you have questions regarding No-Show fees, contact our office @ 336-765-6181.

Revised: April 2, 2014; November 17, 2014, June 19, 2015, October 28, 2016

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay the lawyers' fees which we incur plus all court cost. In case of lawsuit, you agree the venue shall be in Forsyth County, NC. Once your account goes to collections you will be discharged as a patient and asked to transfer your records to another physician. Your delinquent account will also be reported to all three credit bureaus.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until cancelled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: _____

Responsible Party: _____
(if not the patient)

Signature: _____ Date: _____

Co-Signature: _____ Date: _____

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