



**FINANCIAL POLICIES
CONSENT TO CARE AND
AUTHORIZATION FOR BILLING**

Financial Policies

1. Pain Recovery Solutions will bill on your behalf to insurance companies with which we participate. We have provided you with information about limitations your insurance coverage may have and encouraged you to work with your insurer to understand your coverage completely.
2. We will require you bring your account current each time you are in our office for care. For us to continue to book your appointments, we must have some payment on your account (from you, or from your insurance company) every 30 days. We accept VISA, Mastercard, check or cash.
3. If you expect to pay cash for some/all of your care, we may also ask you to execute a payment agreement with us.
4. Unless your payment agreement states otherwise, whenever your account balance exceeds \$100 for 60 days or more we will decline to book further appointments until your account is brought up to date.
5. Please mark your appointments on your calendar. If you miss an appointment without notifying us, or if you cancel or reschedule an appointment fewer than 24 hours in advance, a \$50 "no show" fee will be posted to your account.

Consent to Care

I hereby consent to medical/surgical/behavioral health treatment rendered to me/my family member by medical care professionals associated with **Pain Recovery Solutions, P.C.**

Authorization for Billing

I hereby authorize **Pain Recovery Solutions, P.C.** and the staff/laboratory to bill my insurance company for services rendered and to release medical records to any third party payor as required to receive reimbursement. I authorize payment for covered services directly to **Pain Recovery Solutions, P.C.**

I understand that I am financially responsible for any co-payments, deductibles and/or non-covered services rendered to me or on my behalf. Some insurances (including Medicare) do not pay for preventive services or physical exams. I have reviewed and understand the Financial Policies of this office.

In accordance with the Michigan Public Health Code, if a health professional or other office personnel experiences an exposure to your blood or other body fluids, you may be tested for evidence of the HIV virus. The cost of the test will not be charged to you or your insurance company. The performance and results of this test are confidential. This information will not be released without your written consent, except to those individuals or organizations that have been given access by law, who are also required to keep your records confidential.

Patient Name- Printed _____

Patient/GuardianSignature _____

Date Signed _____

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