FINANCIAL POLICY

It is important that you read this policy carefully before you receive treatment.

We would like to thank you for choosing Trident Pain Center for your health care needs. Our primary concern is that you receive the most appropriate treatment to restore and maintain your good health. Understanding your financial responsibilities and expectations will save you worry and stress later. **If you have questions or concerns about our financial policies, please ask to speak with a Financial Counselor.**

We appreciate your faith and trust in us and thank you for the opportunity to serve your health care needs!

PATIENT BALANCES

Insurance copayments and deductibles are due prior to receiving treatment, along with payment for all services not covered by insurance. Please remember, our primary contract is with you and not the insurance company. For your convenience, we accept cash, checks, and most credit/debit cards.

We require all balances to be paid in full within sixty (60) days of your statement date. We understand that things do happen and financial problems may affect your ability to pay the bill in full. We will do everything we can to work with you. However, we ask that you contact the Billing Department as soon as possible to work out an arrangement that is satisfactory to everyone.

MISSED APPOINTMENTS

You are required to contact our office twenty-four (24) hours in advance of a scheduled appointment to cancel or reschedule. In the event that you contact us the day of, or are more than twenty (20) minutes late for a scheduled appointment, you will be charged a **No Show Fee of $50**. *After two incidences, you will be required to leave a credit/debit card on file to be debited automatically as fees are incurred. If no card is available, you will be required to leave a cash deposit of $50. No Show Fees must be paid in full before we schedule your next appointment.* **Three No Show Policy violations may result in discharge from the practice.**

Patient Signature: _____

ASSIGNMENT AND RELEASE

I hereby authorize Trident Pain Center to release information acquired during the course of my examination and treatment to Health Care Financing Administration and its agents, MediGap, or any third-party carrier as necessary to secure the payment of benefits due. I hereby assign payment of said benefits, to include Medicare and MediGap, directly to Trident Pain Center for any medical services performed.

I understand that I am responsible for all charges, regardless of insurance status, as well as any associated cost for collection if such action should become necessary.

I agree that this authorization shall be valid until rescinded in writing or replaced by an updated form at a later date. A photocopy of the assignment shall be considered as valid as the original.

I have read and fully understand the terms thereof.

PATIENT NAME	DATE
RESPONSIBLE PARTY (IF APPLICABLE)	RELATIONSHIP TO PATIENT
SIGNATURE	WITNESS INITIALS