North Georgia Pain Clinic

PAIN MANAGEMENT SPECIALIST

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Procedure: _____

If we participate with your insurer we will abide by our contract with them in terms of the fee schedule and write-offs required. Failure to provide correct insurance information*, in a timely manner, will result in you being responsible for our fees, in full. Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. Prior authorization is NOT a GUARANTEE OF PAYMENT.

I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denied payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does not make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Check Policy: We do **NOT** accept checks at your initial office visit. We will accept cash, MasterCard or Visa. We do not take 3rd Party checks.

Bad Checks: A $30.00 NSF fee plus a $5.00 Certified Mail charge will be incurred for all returned checks. Returned checks and fees must be paid in cash or by certified funds. Stopped payment on checks is grounds for discharge. After the second (2nd) returned check you will be a **CASH ONLY patient.**

ASSIGNMENT AND RELEASE STATEMENT

By signing below, I understand the billing practices for North Georgia Pain Clinic, PC. I authorize payment of medical benefits to North Georgia Pain Clinic and authorize and release of any medical information necessary to process claims. I understand that I am financially responsible for any copay, coinsurance, deductibles, non-referred and non-covered services as outlined in my health plan.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Witnessed: _____ Date: _____

***Under Georgia Law it is considered "Theft of Services" to obtain care by providing false insurance information**.

_____ **(initial) by signing this Agreement electronically, your electronic signature is the legal equivalent of your manual signature on this Agreement. You consent to be legally bound by this Agreement's terms and conditions. You further agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action, or to otherwise provide North Georgia Pain Clinic online documents, you are accepting any agreement, acknowledgement, consent terms, disclosures or conditions constitutes your signature (hereafter referred to as "E-Signature"), acceptance and agreement as if actually signed by you in writing. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature or any resulting contract between you and North Georgia Pain Clinic. You also represent that you are authorized to enter into this Agreement for all persons who own or are authorized to access any of your accounts and that such persons will be bound by the terms of this Agreement.