Pain Management Assoicates • KC Pain Centers

A Division of Anesthesia Assoicaties of Kansas City

Financial Policy

Thank you for choosing KC Pain Centers as your health care provider. The following statement is our **Financial Policy.**

If you have health insurance coverage:

- You are responsible to supply us with correct insurance information.
- Please notify of us of all changes in your address or telephone number.
- Copays are due at the time of service.
- If prior authorization or referral for medical services is required under my health care, I agree to obtain and furnish such authorization.
- You are ultimately responsible for payment of all charges whether or not such charges are covered and paid (either fully or partially) by your insurance company.

If you do not have health insurance:

- A payment of 500 dollars is due at the time of service. With the remaining portion due within 30 days of services being rendered.

General Financial Policy:

- I authorize the release of my medical information as may be required to process the claims for payment of medical services.
- I acknowledge there is no guarantee to the results of my health.
- Our business office is available from 8:00am to 4:00pm Monday thru Friday to answer any questions or address any concerns you have. If you receive a statement from our office, then we expect payment from you.
- If you disagree with the balance for any reason please contact our business office immediately at 913-428-2900.

Credit/Debit/ACH Policy

- I understand it is the policy of KC Pain Centers to secure my credit or debit card information at the time of my visit. The office acknowledges we must comply with the provisions of the U.S. Law.
- If after a claim is submitted to my insurance carrier: 1) the claim is denied for any reason; or 2) there is patient liability (i.e. Deductible, Co-Insurance, etc.) The office will send a statement notifying me of the balance due. If the amount is not paid within 30 days, then my credit or debit card will be charged the entire balance owed for treatment of services provided to me.
- I understand that my insurance company will also provide me with notification of these charges with an explanation of benefits.
- I understand that in the event that my credit card has been charged for medical services and then my insurance carrier subsequently makes payment to the office for those charges, the office will issue a refund.

I hereby guarantee payment of all charges for medical treatment and services provided to me by KC Pain Centers.

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Signature of Patient Date

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Printed Name of Patient