Financial Policy

You are financially responsible for the medical services you receive. Please review our policies below and sign at the bottom to indicate your agreement to these terms.

APPOINTMENTS:

1. **Co-payments.** Co-payments for clinic visits are due at the time of service. If you are unable to make your co-payment at the time of service, Pain Centers of Iowa, P.C. reserves the right to reschedule your appointment until you are able to make your co-payment. Payment for any outstanding balance is due at your appointment.
2. **Procedural Payments.** Pain Centers of Iowa, P.C. collects your co-insurance payment at the time of your procedural visit. As a courtesy, we will contact your insurance carrier so that we may provide you with an estimate of your patient responsibility, payable at the time of your procedural visit. Your payment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment you may request a refund according to our refund policy listed below. We require a 48-hour notice if your patient responsibility cannot be met by the time of your procedural visit.
3. **Missed Appointments and Late Arrivals**. We require a 24-hour notice if you are unable to make your appointment. If you are more than 15 minutes late, we may reschedule your appointment. We understand that things may arise. PCI makes every effort to send you a reminder. Since spaces are limited, we require a 24-hour courtesy cancellation from you. If you do not show up for your appointment, you will be responsible for a missed appointment fee. Missed office visit appointments are subject to a $50 charge. Missed procedures are subject to a $70 charge (and require a 48-hour cancellation notice). These charges are your responsibility and will not be billed to any insurance carrier. Please be prepared to pay them prior to or at the time of your next visit.

INSURANCE PAYMENTS:

4. **Financial Responsibility.** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.
5. **Coverage Changes and Timely Submission.** It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit in which Pain Centers of Iowa, P.C. must submit a claim on your behalf to your insurer. If Pain Centers of Iowa, P.C. is unable to submit your claim within this period due to not being supplied with your correct insurance information, you will be responsible for the charges.
6. **Self-Pay.** If you do not have health insurance, or if your health insurance will not pay for services rendered by Pain Centers of Iowa, P.C., you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule, available at our front desk. Self-pay patients are expected to make payment in full at the time of service.

BENEFITS AND AUTHORIZATION:

7. **Insurance Plan Participation.** We participate in many, but not all, insurance plans. It is your responsibility to contact your insurance company to verify that your assigned provider participates in your plan. Out of network charges may have higher deductibles and copayments.
8. **Referrals.** Referral and prior authorization requirements vary widely among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by Pain Centers of Iowa, P.C., it is your responsibility to obtain required referral.
9. **Prior Authorization and Non-Covered Services**. Pain Centers of Iowa, P.C. may provide services that insurance plans exclude and that are beneficial to your care. Pain Centers of Iowa may perform these procedures with your approval after an ABN (Advance Beneficiary Notice) form is signed. We will require this signature prior to performing services if they are uncovered by your selected insurance carrier. It is ultimately your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. Pain Centers of Iowa, P.C. as a courtesy to our patients, makes a good faith effort to determine if services we order are covered by your insurance plan, and if so, whether or not prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain this authorization on your behalf as well as your co-insurance responsibility.
10. **Out of Network Payments.** If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to Pain Centers of Iowa, P.C., immediately.

ACCOUNT BALANCES AND PAYMENTS:

11. **Re-assignment of Balances.** If your insurance company does not pay within a reasonable time, we may transfer the balance to be your sole responsibility. Please follow-up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.
12. **Collection of Unpaid Accounts.** If you have an outstanding balance over 120 days and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Pain Centers of Iowa, P.C. reserves the right to refuse treatment due to outstanding balances over 120 days. You agree to pay Pain Centers of Iowa, P.C. for any expenses we incur to collect on your account, including reasonable attorney's fees and collection costs.
13. **Returned Checks.** Returned checks will be subject to a $38 returned check fee.
14. **Refunds.** Refunds for overpayments are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow four to six weeks for your request to be processed. Send requests to: Pain Centers of Iowa, P.C., Attn: Billing Department, 5515 Utica Ridge Road, Suite 600, Davenport, IA 52807.
15. **Statements.** Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates.

16. **Collection Fees, Costs and Venue.** In the event that it becomes necessary for Pain Centers of Iowa, P.C. to employ the services of a collection agency or an attorney to pursue collection of my account, I agree to be responsible for the payment of such collection fees. Interest on my outstanding account shall accrue at the rate of 1.5% per month. Should Pain Centers of Iowa, P.C. file a legal action to collect on my account, I hereby waive venue and agree that venue shall be appropriate in Scott County, Iowa.
17. **Force and Effect.** I have read and understand the above provisions and agree to all terms and conditions as stated. A copy of this consent shall be as effective and valid as the original. This consent and all provisions contained herein shall be in force without expiration or time limitation no matter whether I change my insurance coverage or Plans(s). I understand and agree that none of the provisions of this Consent in anyway seek to limit applicable Federal, State, and Local law, including, but not limited to the Health Insurance Portability and Accounting Act of 1996 ("HIPAA").

AGREEMENT AND ASSIGNMENT OF BENEFITS:

I have read and understood the financial policy of Pain Centers of Iowa, P.C. and agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to Pain Centers of Iowa, P.C. I understand that I am financially responsible for all services I receive from Pain Centers of Iowa, P.C. This financial policy is binding upon you and your estate, executors and/or administrators, if applicable.

Signature: _____ Date: _____