

# ***PAIN AND WELLNESS CENTER***

## ***Financial Policy***

The Pain and Wellness Center participates with most insurance plans including Workman's Compensation, with the exception of MassHealth/Medicaid and Blue Care 65. Motor Vehicle Accidents (MVA) and Liens are not acceptable forms of insurance. You must have active health insurance coverage as well.

All **past due balances** are to be paid in full prior to further treatment unless other arrangements have been made.

New "self-pay" patients must pay for the initial visit, in full, by either cash or credit card (Visa or MasterCard). No personal checks will be accepted.

We require 24-hour notice for cancelled appointments. Repeated cancellations or no shows could result in discharge from the practice.

- **CO-PAY AND DEDUCTIBLE PAYMENTS ARE DUE AT THE TIME OF SERVICE.**
- **A VALID REFERRAL MUST BE OBTAINED PRIOR TO YOUR VISIT. (Without a valid referral your appointment will be cancelled and/or rescheduled until the appropriate referral is obtained.)**
- **PAYMENT CAN BE IN THE FORM OF CASH, CREDIT/DEBIT CARD OR MONEY ORDERS. NO PERSONAL CHECKS.**

### **INSURANCE**

Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, pre-existing conditions, etc, other than to supply factual information as necessary. **You are responsible for the timely payment of your account.**

### **PPO/HMO**

Each time you make an appointment with any physician, it is your responsibility to make sure your physician is currently under contract with your plan and to obtain the appropriate referral or authorization for your visit. **Verification of your plan is required. Therefore, you must show your current card to our receptionist at each visit.**

### **MINORS ACCOMPANIED BY ADULT**

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The parents (or guardian) accompanying a minor are responsible for full payment at time of service.

Your signature below indicates that you have read and understand our **Financial Policy**. If you have any questions, or need any further information please let us know.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name