Jeff L. Buchalter, MD, DABAPM
David E. Fairleigh, MD, DABAPM
Mark E. Larkins, MD, DABAPM
Bryan Boerjan, DC
Veronica Kings, PA-C
Audrey Sisney, ARNP-BC

FINANCIAL POLICY AND AGREEMENT

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered by Gulf Coast Pain Specialists. I am responsible for any applicable deductible, co-payments and coinsurance prior to the provision of services. Gulf Coast Pain Specialists may file **ALL** claims for payment with my insurance company as a courtesy to me. If the insurance company fails to pay in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts due. Payments may be made in the form of Cash, Check, Visa, MasterCard and Discover. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection including attorney fees.

I hereby authorize and assign all payments, insurance or Medicare benefits for medical services and/or procedures rendered to the payment, directly to Gulf Coast Pain Specialists. I hereby authorize Gulf Coast Pain Specialists to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance company or Medicare.

If my insurance company requires referrals/authorizations, it is my responsibility to obtain such and if not, then I will be responsible for any unpaid balance.

By signing this agreement, I acknowledge that I have carefully read, understand, and agree to the above terms and conditions. I also understand that it is mandatory to tell Gulf Coast Pain Specialists if another party is responsible for paying for my treatment. Section 1128B of Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

_____ _____

Patient Signature Date

NO SHOW POLICY OF GULF COAST PAIN SPECIALISTS

There is a 24 hour notice required when canceling or rescheduling an appointment. Otherwise, there may be a $50.00 fee charged for missed office visits and for procedures.

_____ _____

Patient Signature Date

NOTICE OF PRIVACY PRACTICES RECEIPT

I acknowledge that I have received a copy of Gulf Coast Pain Specialists Notice of Privacy Practices.

_____

Patient Name

_____ _____

Patient Signature Date