



## Financial Policy

If you have questions regarding your insurance, we will try to help. However, questions relating to specific coverage issues must be directed to your insurance company's member services department. Their telephone number should be listed on the back of your insurance card.

All applicable co-payments, deductibles, co-insurance and personal balances, both current and prior, are due at the time of service unless other payment arrangements have been made. In some cases, you may be asked to pay the balance of your account or make payment arrangements prior to making your next appointment.

River Cities Interventional Pain Specialists participates with and accepts most insurance plans. Patients are required to furnish proof of insurance at the time of service. As a courtesy to our patients, we will be happy to file the insurance claim(s) for services rendered.

Annual deductible amounts will be the obligation of the guarantor. If the patient has met his/her deductible for the current year and can verify this with an Explanation of Benefits from his/her insurance carrier, the remainder of the patient responsibility (such as 20% for most insurance plans) will be due at the time of the visit.

Co-payments for HMO's, PPO's, and other managed care plans must be paid at the time of service. Balance billing patients for their co-pays is a violation of many managed care contracts and will not be allowed. Co-payments will be collected at check-in before the provider sees the patient. If the patient does not have the co-pay at the time of the visit, the patient may reschedule the appointment in order to meet the co-pay requirement.

Monthly statements are generated and mailed to patients/guarantors to make them aware of any outstanding balance after insurance coverage has been exhausted. Any outstanding balance is considered the guarantor's responsibility regardless of insurance coverage.

For your convenience, we accept cash, checks, and most major credit cards. You may also pay your bill online through our website (*shown below*) or your patient portal. Please note that there is a \$35.00 service charge for all returned checks and, if a check is returned for insufficient funds, the practice will no longer accept checks for payment from the individual.

We understand that there may be times and circumstances that come up where you are unable to pay your entire bill. In these situations it is very important that you contact our billing office at (318) 797-5848 so a financial representative can assist you in setting up a reasonable payment plan and to keep your account from being sent to a collection agency. The physician and/or practice manager must approve payment plans and discounts. Payment arrangements are understood and agreed upon by the patient and provider prior to services being rendered.

An account will be deemed delinquent after 90 days from the date of service or from the date services were denied or paid by the insurance carrier for outstanding balances owed.

If you fail to meet the financial obligations agreed upon in this financial policy or have other payment arrangements made, your outstanding balance will be sent to a collection agency. You will be required to pay your entire balance and any collection agency fees, up to 25% of your account balance, before being scheduled for any further appointments.

If you have billing related questions, please contact our billing office at (318) 797-5848 and select option 3.

**ACKNOWLEDGEMENT**

I understand that I am responsible for the cost of the medical services rendered and agree to pay any, and all amounts not paid by others within thirty (30) days from the date billed unless I made previous arrangements with my insurance company. I further agree to pay all collection costs including but not limited to court costs, and reasonable attorney’s fees, if it becomes necessary to turn this account over to an outside party for collection.

My signature below verifies that I have read and understand the *Financial Policy* outlined above and that a copy of the policy is available to me upon my request.

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Print Patient Name Date of Birth

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Patient/Guardian Signature Date