AUGUSTA PAIN CENTER
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PATIENT POLICIES AND PROCEDURES

I. CANCELLATION AND NO SHOW POLICY

As our goal is to meet the needs of our patients, we will make every effort to schedule your appointments as efficiently as possible. In return, ***it is your responsibility to make every effort to keep your scheduled appointments and to arrive at your specified time.*** We do realize that unanticipated events can occur and may prevent you from keeping your appointment. In fairness and consideration to other patients, however, we request that you notify our office immediately when you realize you will not be able to keep your appointment. At least 24 hours is required for cancellations to avoid a charge that is NOT covered by your medical insurance policy. A patients who does not show for an appointment and who does not give 24 hours notice will be charged a **$40.00 cancellation fee**. Patients that fail to show on three occasions may be discharged from the practice for non-compliance, and a letter will be sent to the referring physician.

Due to a significant increase in patient no shows and last minute cancellations, a reservation for your future scheduled appointments will be necessary. At the time of scheduling, a credit card will be required only for the purpose of holding your scheduled appointment time. The credit card will not be utilized for any other reason and will not be used unless you fail to show for your scheduled appointment or you do not provide at least 24 hours notice of cancellation.

I hereby authorize Augusta Pain Center to charge my credit card $40.00 for any office appointment when I do not show or do not cancel at least 24 hours in advance.

Circle one: VISA DISCOVER MASTERCARD

CARD #_____ Expiration date:_____

Cardholder Signature:_____

Initials _____

II. APPOINTMENT POLICY

--Late appointments: Patients who arrive late for their scheduled appointment times will be worked into the schedule or will be seen at the end of the schedule.

--Wait times: This is a specialty office. We strive to keep to the scheduled appointment times. However, in this practice there are some circumstances beyond our control that can result in a longer wait time for everyone. We provide the necessary time and treatment for all our patients and some may require more time than others for unforeseen reasons. For every appointment, patients should plan to be her for one to three hours, however, this time may wary.

--Multiple providers: We now have four providers caring for our patients; therefore, some patients may be called before others who have been waiting longer because they are seeing a different provider. All patients will be seen in the order they are scheduled. Patients who arrive before their scheduled appointment time will not be seen early unless we have had a cancellation or no show.

Initials _____

III. PHYSICIAN'S ASSISTANT

The Augusta Pain Center utilizes a Physician's Assistant licensed by the Georgia State Board of Medical Examiners, who evaluates and treats patients according to the guidelines that have been set by this board. Under the physician's supervision, the PA is directly involved in patient care and together they coordinate the best treatment plan for the patient's needs.

I hereby acknowledge that I have read and understand the above policy and I agree to abide by these guidelines.

Initials _____

IV. PRESCRIPTION MEDICATION POLICY

Prescriptions will only be filled during regular business regular business hours. Prescriptions will be faxed to your pharmacy whenever possible; otherwise they can be picked up at your regular appointment. All calls regarding refills received after 2:00 PM will be returned the following business day. Every effort will be made to return all other calls before the end of the day. NO prescriptions will be filled on Fridays.

A medication for an accepted pain problem may be prescribed for you that may not have an indication by the FDA. This is common practice by physicians nationally that may be based on medical evidence when it is considered an appropriate treatment.

Initials _____

V. FINANCIAL POLICY

It is our desire that payment of your account is as easy and convenient as possible. We will assist you in any way we can to facilitate the settling of your account. In order for us to keep billing fees to a minimum, it is absolutely necessary for you to provide us with accurate and up-to-date insurance information at EACH visit. It is your responsibility to notify us of any changes in insurance so that claims can be filed correctly. Approval from your insurance company does not guarantee payment. The patient is ultimately responsible for payment of services rendered.

Initials _____

VI. BILLING

You will receive a bill for services provided at each of your visits. Please note that physician services are different from facility charges. The bill that you receive from Augusta Pain Center is for physician services only. When you have a procedure, you will receive a separate bill from the facility. This is customary and is to cover the costs to the facility for supplies, equipment, medications, personnel, the procedure room and observation following the procedure. As a courtesy to you, we will file the claims for physician services to your insurance company.

Initials _____

VII. PAYMENT

In accordance with the agreement you have with your insurance company, any deductible or co-pay is required at the time services are rendered. Failure to keep your account current may prohibit future services until your account is current. Payments may be made by cash, check, debit card, money order, or accepted credit cards.

Initials _____

VIII. AUTHORIZATION TO RELEASE INFORMATION

Consent and authorization is hereby given to Augusta Pain Center, its associates and billing agents to release to any state agency, federal agency, insurance company or third party such information as may be necessary for processing of claims (including copies of any medical records, including those that relate to history, treatment, diagnosis, prognosis, psychiatric care, drug and substance abuse, HIV/AIDS), or any confidential information that may be required for any health related utilization review or quality assurance activities.

Initials _____

IX. ASSIGNMENT OF INSURANCE BENEFITS

As a courtesy, this office makes significant efforts to verify insurance coverage and obtain authorization for the services rendered. However verbal communication with the insurance company may not be accurate, nor will it guarantee payment for rendered services. By signing this document you authorize and direct the following state agencies, federal agencies, insurance companies, and/or third party payers to pay direct to Augusta Pain Consultants, PC for physician service and you agree to be financially responsible for services not covered by your insurance.

Initials _____

X. HEALTH INFORMATION PRIVACY ACT (HIPAA)

According to the federal Health Information Privacy Act, effective April, 2003, health professionals, using their judgement, may disclose to a family member, other relative, close personal friend or/and other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Please list those persons that you wish to receive information related to your care, including billing and appointment information:

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_____

_____

_____

_____

_____

Also indicate whether any information may be left on an answering machine or voicemail:
YES_____ NO_____

XI. CONTRACT AS TO LEGAL FEES AND COLLECTION FEES

If legal action becomes necessary to collect for plaintiff's services rendered, the undersigned party shall be responsible for plaintiff's reasonable attorney fees, all cost of collection, court costs, and any other relief to which plaintiff may be entitled under law. I agree that in the event that court action becomes necessary, the plaintiff's case shall be tried in Richmond County , Georgia regardless of defendant's county or state of residence. I understand the fee charged by the physician may include amounts not covered by insurance.

I hereby acknowledge that I have read and understand the above policies and procedures, and I agree to abide by these guidelines:

Printed name_____ Date _____

Signature_____

By _____ Relationship _____
(legal guardian or nearest relative, if patient is unable to sign)