George Macrinici, M.D./Advanced Pain & Spine Management, S.C.
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Financial Policy

Our practice is committed to giving you the best healthcare possible and we want you to completely understand our financial policy. We believe that part of good health care practice is to establish and communicate a financial policy to our patients. The Pain Management Center staff is happy to assist you with any questions you may have about your account or balance with us.

Our Responsibilities. We understand that health insurance can be confusing. Therefore, while it is ultimately your responsibility to know your insurance plan, we will make reasonable efforts to assist you by verifying that you have an active policy at your insurance company. This does not guarantee payment of your services, it only verifies that you have actual coverage. As a courtesy to you, our office will send bills for our services to your insurance company on your behalf. We will bill your insurance company in a timely manner. We will keep your personal medical and account information confidential according to state and federal law.

1. PAYMENT is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of you visit. We do ask for a copy of an ID card of license due to the many cases of identity theft in the news lately. (Please do not be offended!)

2. INSURANCE We are participating providers with several insurance plans. We will file all these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff can not guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

3. LATE CHARGES of 12% annually will be applied to all patient balances 90 days old or greater.

4. RETURNED CHECKS will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to this office are subject to collections.

5. ACCOUNTING PRINCIPALS Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

6. FORMS FEES: completing insurance forms, copying medical records, etc... requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $10 per occurrence plus and applicable notary fees (if required). George Macrinici, M.D./Advanced Pain & Spine Management, S.C. will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for copying has been received and after patient has signed the form authorizing records' release.

7. BILLING Questions: If you have questions in regard to any of your billing statements please don’t hesitate to call our office and we will address them appropriately.

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8. CANCELLATIONS OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $25 missed appointment fee.

9. RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to George Macrinici, M.D./Advanced Pain & Spine Management, S.C. for charges not covered by the assignment of insurance benefits.

10. ASSIGNMENT OF INSURANCE BEBEFITS: I hereby assign, transfer, and set over directly George Macrinici, M.D./Advanced Pain & Spine Management, S.C. sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize or George Macrinici, M.D./Advanced Pain & Spine Management, S.C. to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information George Macrinici, M.D./Advanced Pain & Spine Management, S.C. and to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

11. INSURANCES WE WON'T BILL/PATIENTS WE WON'T ACCEPT INTO THE PRACTICE: We are not currently eligible for Medicaid. I will notify George Macrinici, M.D./Advanced Pain & Spine Management, S.C. in writing immediately if I become eligible for these payors, thus terminating my care from George Macrinici, M.D./Advanced Pain & Spine Management, S.C., who WILL NOT accept new patients with Medicaid nor bill this payor if patients switch after becoming established with George Macrinici, M.D./Advanced Pain & Spine Management, S.C..

12. RELEASE OF INFORMATION: I hereby authorize the and direct George Macrinici, M.D./Advanced Pain & Spine Management, S.C. to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

13. COLLECTION FEES: I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

I have read and understand the practice's financial policy and I agree to be bound by its terms.

I also understand and agree that such terms may be amended by the practice from time to time.

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Signature of Patient Date
(or Guarantor, if applicable)

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Please Print the Name of the Patient