Financial Responsibility Policy

Thank you for choosing Pain Management of North Idaho as your health care professional. We are committed to providing quality care and placing the needs of our patients first.

Pain Management of North Idaho, (PMNI), and **North Idaho Pain Center, (NIPC),** participate with most insurance plans. We are contractually obligated to bill your insurance if we are a contracted provider. Based on the coverage you and/or your employer selected there may be some (or all) services you receive that may be non-covered or considered not medically necessary. Please be aware that those balances will be your responsibility and are due at the time of service You will be expected to sign a waiver stating you will be financially responsible for the bill and we will not bill your insurance. If we are a contracted provider, your insurance company requires us to collect applicable co-pays and estimates of coinsurance and deductibles at the time of service. Co-payments and patient responsibility amounts as shown on the Explanation of Benefits (from your insurance plan) for previous visits are also part of your contract with your insurance plan and will be collected at the time you check in for your appointment. If **PMNI & NIPC** has to mail you a statement for any unpaid co-pay balance, you will be charged a $15.00 fee for each unpaid co-pay amount. The fee is non-refundable and will not be waived. Non-payment could result in your appointment being rescheduled until payment is received.

Our Responsibility:

- To bill all claims to your insurance carrier(s) in a timely manner if applicable.
- To assist you in resolving any problems with claim payment.
- Notify you if a service is not covered or authorized. Give you the option to pay for not covered services.

Your Responsibility:

- To provide us with current and accurate information to submit your claims correctly
- To pay your co-payment, estimated coinsurance, and/or deductible at the time of service
- To pay any remaining account balance after insurance payment within 60 days of receipt of your first statement from us.

Account Balance: Any outstanding balances are due in 30 days after the insurance pays. If your insurance doesn't pay us, the full amount is due no later than 60 days after the date of service, unless prior arrangements have been made with our business office. Delinquent accounts and unpaid balances may result in referral to our collection agency. Future appointments may be refused or postponed until all balances are paid. Please contact our billing office at **(208) 664-2363** with any questions you have regarding your account balance.

Provider may obtain and retain in their files a one-time payment authorization from a patient (or the patient's representative) applicable to any current and future services. The provider should have the patient sign a brief statement such as:

Name of Beneficiary _____ ID _____

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Pain Management of North Idaho. I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signature _____ Date_____

For Physician & Nurse Practitioner Clinic Fees:

Third Party: If you are involved in an incident/accident (MVA, slip and fall, etc.), that will result in your medical bills being paid by a third party instead of your medical insurance coverage, please note that all necessary information to bill the Third Party payor will be required by **PMNI**. Patients are privately responsible for these claims. A down payment of $250.00 is required at the time of service, unless you can provide proof of coverage from an insurance we are contracted with. We will bill the third party once we are given the claim number and the insurance contact name and address. It is your responsibility to provide this information. If it is not received, **PMNI** will be billing you for the full financial responsibility, and you will need to provide this information to the third party payor for reimbursement. If your medical expenses have been exhausted through your auto carrier, your medical insurance carrier will require you to have a med pay exhaust letter before we will bill your medical insurance carrier. We will not get involved in legal disputes of liability. Ultimately it is your financial responsibility.

Workers' Compensation & L&I: If you are involved in an incident/accident at work (slip and fall, etc.), that will result in your medical bills being paid by Labor and Industries (L&I) instead of your medical insurance coverage, please note that all necessary information to bill L&I will be required by **PMNI**. We will require the claim number, the insurance contact name and address and authorization to be seen. It is your responsibility to provide this information. If it is not received**, PMNI** will be unable to provide service to you.

Self-Pay Patients: This status is reserved for patients who have no insurance coverage at all. Please be aware if you have insurance coverage, you will not qualify for this status. **PMNI** has a fee schedule for patients with no insurance coverage. A down payment of $250.00 is required at the time of service unless other arrangements have been made prior to treatment. We offer a discount of 20% for cash payment in full on the day of service. Payment must be made in full prior to services being rendered. Non-payment may result in your appointment being rescheduled until payment is received.

No-Show Policy: If you are not able to make your appointment, please call and cancel at least 1 business day prior to the scheduled appointment. There is a $100.00 charge for not showing to an appointment or a for cancelling less than 24 hours before appointments.

The Ambulatory Surgery Center Professional and Facility Fees:

In order to achieve the practice goals of providing the finest medical care at the lowest possible cost to our patients, we ask your assistance and your understanding of our payment policy.

For procedures performed in our surgery center, **you will receive a separate bill**. All insurance companies will be called to verify coverage, and pre-admission requirements, deductibles, coinsurance, and co-pays when the procedure is scheduled. A written **Estimate of Patient Responsibility** will be presented upon your request, prior to your procedure. In most cases, you will have ample time to review these fees, ask questions, make payment arrangements, and/or contact your insurance carrier. For cases scheduled with 48 hours or less, you will receive a phone call to discuss these issues.
If you have insurance coverage, we are happy to help you receive your maximum allowable benefits and will file the claim for you. By state law, your insurance carrier must remit payment or deny your insurance claim within 30 days of initial filing of the claim. If an insurance problem occurs, you may be asked to assist us in contacting your insurance carrier. We believe it is necessary to work together to resolve any insurance problem.

FULL PAYMENT OF YOUR ESTIMATED PORTION OF THE SURGERY CENTER FEES (PROFESSIONAL, AND FACILITY,) ARE DUE PRIOR TO YOUR PROCEDURE OR AT THE TIME OF SERVICE. IF PAYMENT IS NOT RECEIVED, YOUR PROCEDURE MAY BE RESCHEDULED. (Unless other payment arrangements are made PRIOR to procedure.)

Payment Options:
- You may pay by cash, debit, credit card or check.
- Balances older than 60 days will be considered delinquent and may be referred to our collection agency.

Returned Checks: A $20.00 fee will be charged for all returned checks.

This is an agreement between **PMNI & NIPC** and the Patient/Guarantor named below. By signing this agreement, you are acknowledging that you understand our insurance and financial policies and are agreeing to pay for all services that are received.

I acknowledge receipt of Pain Management of North Idaho & North Idaho Pain Center patient financial policy and have read, understand, and agree to comply with these policies. I understand that I will be financially responsible for services that are patient responsibility.

Date: _____ **Patient's Signature:** X_____

Print Name:_____