ADVANCED PAIN CENTERS, S.C.
TREATMENT POLICIES

Thank you for choosing Advanced Pain Centers for your chronic pain care. We are committed to the treatment of your condition. In order to provide your care, we require both treatment and financial compliance. Your clear understanding of our policies is important to our professional relationship.

NARCOTIC/OPIOID ADMINISTRATION

Because your condition may require the dispensing of narcotic substances, we require you to sign a treatment agreement with us. This agreement outlines the conditions under which treatment is provided. This agreement is required of all patients and is signed at the time of your first service. We may also ask you to sign updated versions of this agreement from time to time. If you refuse to sign this agreement, no further care will be provided.

FINANCIAL POLICY

If your insurance plan requires a copayment, it is payable at time of service. If you present without the copayment, we reserve the right not to see you.

We are happy to bill your primary insurance company directly if a copy of both sides of your insurance card is provided at time of service as well as all required demographic information necessary to file your claim. If you fail to provide the necessary demographic information to file your claim, you will be responsible for payment in full at time of service. If payment is not received from your insurance company in ninety days, you will be expected to assist in the resolution of the open claim. If the claim continues to be unpaid after 120 days, we reserve the right to bill you directly. It is in your best interests to ensure that the correct insurance information is provided at time of service.

If you have HMO coverage it is your responsibility to obtain the necessary referral for your visit or procedure and forward a copy of this referral to our Insurance Specialist prior to your visit or procedure.

Filing secondary insurance is a courtesy to the patient and we will make one attempt to do so and then the balance will be your responsibility. If we receive payment from you and your secondary carrier, a refund of the overpayment will be made to you. We will not file tertiary insurance but will provide a claim to you upon request. You are responsible for all tertiary balances.

Self pay patients are required to pay in full at time of service. We will discount our fees for self pay patients only if payment is made at time of service. We accept cash, check, money order, Master Card, Visa, American Express, and Discover.

If for any reason a payment is dishonored by your bank, there will be a $40.00 service fee added to your bill and you will be required to pay by cash, certified check , money order or credit card for all future services.

We do accept Workers Compensation and Personal Injury cases. We will only file these claims with your regular insurance if a written denial from the workers compensation or personal injury carrier is received. **We accept liens only for services provided in our office or fluoroscopy suite.** All the necessary legal contact information must be provided in advance of your service to allow us time to process the necessary lien paperwork.

We are participating providers for many plans, however it is your responsibility to verify that the provider you are to see is in your network. If the provider is out of network and you see this physician, you are responsible for payment in full regardless of any insurance plan's arbitrary determination of usual and customary fees. There may be times when our physician is out of the office and you are required to see a physician who is not in your network. In these instances, we will work with your insurance plan to obtain in network benefits and you will not be responsible for payment of the entire fee.

There may be certain services that are not likely to be covered by your insurance plan. We may request you to sign an Advanced Beneficiary Notice (ABN) acknowledging payment responsibility. The reason for the likely denial is indicated on this form. We are required by your insurance plan to obtain this form before providing the service. If you refuse to sign this form, we will not provide the service without payment in full at time of service.

If you fail to meet your financial obligations in a timely manner, we reserve the right to discontinue care and refer your account to collections. **You are responsible for any agency, attorney, interest and other charges associated with collections.**

OFFICE POLICIES

DEMOGRAPHICS

All patients are required to provide the necessary demographic information in order for us to provide care and bill for our services. You are required to notify us when any demographic information changes. You are required to provide a copy of your insurance card if your coverage changes. You are required to sign a Patient Information form and medical records release annually. We reserve the right to change the required demographics in order to comply with legal or billing requirements. If you move out of Illinois, you will have sixty days to transfer your care to a provider in the state that you reside.

PRIVACY

A copy of our complete privacy policy is provided to you at time of your initial visit. This policy explains your rights including your right to see and copy your records, to limit disclosure of your protected health information, and to request an amendment to your record. You may revoke in writing any consent for release of your health care information, except to the extent the Practice has already made disclosures with your prior consent.

Because of the privacy regulations we are not at liberty to discuss your treatment with anyone unless you specifically designate your permission to do so. If you wish to allow access to your protected health information to any individual, ask our receptionist for an Access to Medical Records form. By signing this release, you allow us to discuss your care with the specified individual(s). If a family member has concerns about your care, we may not discuss these concerns without your written permission.

APPOINTMENTS

We no longer call existing patients in advance of their appointments to remind them of the time and date. For all new patients, please be sure to provide a telephone number where you may be reached. If you have voice mail on your contact telephone number, our staff will leave a message including the time, date and location of your appointment.

We ask that you make your next appointment at time of service. We will no longer be able to meet your specific needs for dates and times if you fail to make your next appointment in a timely fashion. **Urgent or emergency appointments** will be made if you have difficulty or serious side effects following a procedure. In these instances, you should call the OR nurse to report your status post procedure concerns. **Emergency appointments** will also be scheduled if you have serious side effects from your medications or other complications following an office visit unrelated to a procedure. Please call our physician assistant to report any serious medication concerns (unrelated to a procedure). There are no additional time slots available to accommodate patients who call at the last minute to schedule routine appointments. **If you wait to schedule your appointment you will be required to take whatever time slots are available.** Timely follow up appointments are a requirement of your care and we reserve the right to discharge you if you continually call at the last minute or fail to keep your regularly scheduled appointments.

We require 24 hours notice if you intend to cancel your appointment. Should you cancel, reschedule, or no show for an appointment twice without 24 hours notice you will be required to hold your next appointment with a credit card. If you cancel this appointment for any reason, your credit card will be charged and you will be discharged from the practice for failure to uphold your treatment agreement.

If you are scheduled for a procedure at any location and cancel without a 24 hours notice to our office, a cancellation fee of $250.00 will be billed to you directly. You are required to pay this fee before any further services are provided. Failure to pay this fee for more than thirty days will result in discharge from the practice and referral of your account to collections.

If you are thirty minutes or more late for your appointment, **you will not be seen** and you will need to reschedule your appointment. If you are late but less than thirty minutes, we reserve the right to reschedule your appointment or see you as the schedule permits.If you are a new patient and do not complete your forms in advance you are required to be at the office at least 45 minutes in advance of your appointment to complete the necessary forms. Failure to so will result in the rescheduling of your new patient visit.

PSYCHOLOGICAL EVALUATIONS

Because of the nature of our treatment, there may be occasions when the physician determines that a psychological evaluation is necessary. For example, many healthcare plans require evaluations prior to intrathecal pump or dorsal column stimulator placements. **We reserve the right to discontinue care if you fail to obtain an evaluation as requested.**

STAFF

We require our staff to address our patients with professionalism and we ask our patients to do the same. If at any time our staff feels that your tone or language is offensive or abusive, we expect them to terminate the conversation immediately and notify the Chief Operations Officer. **We will document your record and depending on the severity of the situation, you may be discharged from the practice.**

COMPLAINTS

If for any reason you are unhappy with the care provided by Advanced Pain Centers, we ask that you submit a written explanation of your concerns to:

Compliance Officer
Advanced Pain Centers
2260 W. Higgins Road, Suite 101
Hoffman Estates, IL. 60169

This allows our Compliance Officer to research the matter and respond to your concerns in writing within thirty days. If for any reason additional time is needed, our Compliance Officer will contact you regarding the delay.

We are committed to providing the best possible treatment and ask your cooperation in following our policies.

I ACKNOWLEDGE RECEIPT OF A COPY OF THE PRACTICE'S NOTICE OF PRIVACY POLICIES.

I READ AND UNDERSTAND THE ABOVE POLICIES AND AGREE TO ABIDE BY THEM. I FURTHER UNDERSTAND THAT FAILURE TO DO SO MAY RESULT IN MY DISCHARGE FROM THE PRACTICE.

Patient Name (**PRINT**)	Patient Signature	Date