Spectrum Pain Clinics

CREDIT POLICY

Your physician has chosen to perform your procedure at Spectrum Pain Clinics. All procedures performed here will have a Facility and Physician charge that are Incurred. In the event that you require an anesthesiologist, there will be separate charges for them in addition to ours, and your physicians.

Many patients are covered by health Insurance contracts, which provide for reimbursement for specific medical fees. If you are not familiar with your policy, it is suggested that you discuss coverage with your carrier before charges are Incurred. All Insurance policies are contracts between you and your Insurance carrier, Your facility bill is an agreement between you and your facility. Our fees may be more or less than the payment schedule of any insurance companies' arbitrary determination of Usual & Customary. Our facility is a "Preferred Providers" for certain HMO's and PPO's and the contracts that we have signed with these specific carriers supersede our Usual & Customary policy. For our patients who are subscribers to these Insurance plans, you will not be billed for amounts above our negotiated fee schedule, with the exception of co-pays, co-Insurances and deductibles amounts as stated per your contract.

You will receive a statement each month for any unpaid balances. Balances due are payable within 60 days of your first statement. We will charge a $ 25.00 fee for all returned checks. In the event that your account is forwarded onto our collection agency, you will be responsible for their fees associated with us having to submit your account to collectlons. We accept MASTERCARD/ VISA.

Spectrum Pain Clinics accepts Medicare Assignment. We will submit Insurance claims for you as a courtesy, but It remains the patient's responsibility to make sure your claims are paid. Spectrum Pain Clinics does not handle any referral processes for your procedures.

Extended payment plans can be arranged through our billing office. These plans are based upon financial circumstances of each patient.

I, the undersigned, have read and understand the above Credit Policy.

Signature Insured/ Authorized Person _____ Date _____

Patients Name, Print _____