

Processing Fee Schedule for Uncovered Medical Services

NC Pain Management Services, PA is dedicated to serving our patients with the highest quality of care at the lowest possible cost. The **purpose of this statement** is to disclose and help you understand our billing policy. We encourage open discussion of services and fees prior to treatment. It is ultimately your responsibility to see that all charges are paid.

The following fee schedule will apply to those services not covered by your contractual medical insurance plan. This financial policy information is specific for **NC Pain Management Services, PA** and therefore any questions should be directed to our billing service, currently "**EJ and Associates, LLC**", at their toll free number **1-800-427-7487**.

Since insurance plans vary, we recommend that you become familiar with your plan's benefits as they relate to deductibles, **co-pays**, non-allowed charges, and pre-certification. Remember that your insurance coverage represents a contract between you and your insurance carrier. If you have an insurance policy, such as an HMO/PPO that requires **pre-certification / pre-authorization or referrals for any service, including office visits, it is your responsibility** to obtain it, update it, and keep them current. If you need any help, our staff will be more than happy to help you through the process. In your insurance card there will be a telephone number, which is the number that you should call for pre-approvals or information on deductibles, co-pays, allowable, and pre-certification. You can also use this number to find out what your insurance company allowable is, for the proposed treatment. If you have any questions about the requirements of your coverage, please contact your employer or insurance carrier. We cannot interpret policies for you. Remember that the difference between the allowable and the cost of the treatment will be your personal responsibility. You will be responsible for services rendered that are outside the scope of any referral issued by your insurance carrier. You are expected to be aware of any and all conditions of your insurance coverage. Please provide us with information on any secondary insurance coverage that you may have, as they may cover the difference.

Your **payment** or **co-pay** is due at the time of your service. This may be paid in cash or using your credit card. Please indicate your preference to the receptionist.

Certain services are not covered by your healthcare insurance. The following list represents some of these services along with their current processing fees. This **processing fee** is due at the time the service is requested. This may be paid in cash or using your credit card. Please indicate your preference to the receptionist.

Copies of medical records	Service provided by Hospital, at a cost. Call Patient Accounting Office: 336-538-8400
Detailed Letters*	\$65.00 (per page)
Disabled Parking Form*	\$20.00 (Only given to patients in wheelchairs)
Impairment Evaluation*	\$350.00
Insurance Form*	\$20.00 (Payment should be handed in with paperwork to be completed)
No-shows or Missed Appointments	\$50.00 (No charge if cancelled with more than 24 hours in advance)
No-shows or Missed Procedures	\$100.00 (No charge if cancelled with more than 24 hours in advance)
Phone calls to nursing staff	Free service provided by Hospital
Phone calls to physician	\$50.00 (per every 15 minutes, or fractions thereof) There is a minimum charge of \$50.00 for non-emergency phone calls. This fee applies <u>only</u> to non-emergency phone calls. There is no charge for contacting your physician during an emergency.
Phone calls with Family Members	Restricted by HIPAA privacy laws.
Preauthorization	Free service provided by Hospital

* These services require the form below to be completed and submitted to us with payment in full before service is completed.

Service Request Form

Please mark the requested service and complete form. Allow 2 weeks for completion.

- Detailed Letters* **\$65.00** (per page)
- Disabled Parking Form* **\$20.00** (Only given to patients in wheelchairs)
- Impairment Evaluation* **\$350.00**
- Insurance Form* **\$20.00**

Last Name: _____ First: _____ Middle Initial: _____

Date of Birth: _____ Medical Record Number: _____

Address: _____

Phone: _____

Signature: _____

Attach payment to request form and submitted to receptionist.

Request receipt.

- Expedite Service Requested **\$100.00** (Depends on physician availability. Allow 2 business days)