Patient Financial Agreement

I understand that in consideration of the services provided to me or the patient for which I am the responsible party, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at University Anesthesiologists, LLC, DBA University Center for Pain Management (UCPM). I further understand that such payment is not contingent on any insurance, settlement or judgement payment. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

UCPM Responsibilities:

- We understand that health insurance and payer policies 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 or with a government payer. This does not guarantee payment of your services, it only verifies that you have actual coverage.
- We will assist you if you are not sure if a service is covered by your plan, by calling your payer in advance to see if you are going to be responsible for the bill or to receive precertification if required.
- 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 or other payer in a timely manner. We will abide by rules of the payers (to include our responsibilities to collect all deductibles and co-pays and other non-covered services) that we are contracted with or in – network with.

Patient Responsibilities:

- Payment of my portion (or an estimate) of the practices charges is expected when services are rendered. I am responsible for any appropriate charges not paid by my insurance company, managed care, government, or other payer. I also understand that it is my responsibility, not UCPM's responsibility, to know what services are covered and not covered by my insurance company, and if preauthorization of my visit is required. I understand that I am responsible for payment if a third party payer does not deem my procedure to be beneficial or medically necessary. If I fail to provide the correct insurance information and receive a denial, I am responsible for payment. If I do not follow the requirements of my insurance plan and receive treatment without authorization of the payer, I am responsible for payment.
- Know whether or not UCPM participates with your insurance or other payers plan.
- Keeping the appointment time. If I fail to keep my appointment time, I may be subject to fees or charges, or discontinuing of services.
- Keeping the balance of my account current. This balance may include payment of any "no show" or cancellation fees, any collection fees or outstanding balances after third party payers have paid, or payment for non-covered services. I realize I may be turned over to collections or not be able to schedule another appointment or receive further services.
- Knowing and complying with all Patient Policies and Procedures.

Patient (and/or Responsible Party):

I have received and understand the Financial Agreement of the UCPM. I do hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to UCPM. In the event I receive payment directly from my insurance company for services rendered by UCPM, I agree to endorse any check received to UCPM.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THIS FINANCIAL AGREEMENT.

Date _____

Patient signature _____

Printed Name of Patient _____

Parent, Guardian, or

Legal Representative (Responsible Party) _____

Printed Name of Parent, Guardian, or

Legal Representative (Responsible Party) _____

Relationship to Patient: _____