IPI Interventional Pain Institute
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2243
Excellence in Pain Management

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Fellowship Trained

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INTERVENTIONAL PAIN INSTITUTE FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you anytime. Your clear understanding of our Financial Agreement is important to our professional relationship. Please ask if you have any questions about our fees, financial agreement or your financial responsibility. Please initial on each line to confirm your understanding.

1. ___ **APPOINTMENTS** – This practice requires at least **24** hours advance notice for appointment cancellations. A **$65.00 fee** will be charged to patient's account if a patient fails to give advanced notice and does not show for their scheduled appointment.
2. **___ REFFERALS –** If your plan requires a referral from your primary care physician, it is **YOUR** responsibility to obtain a referral prior to your appointment. Referrals must be received in our office prior to your appointment. If no referral is received by the time of service, you will be responsible for the charges.
3. **___ CO-PAYMENTS –** By contract with your insurance carrier, we **MUST** collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of $10.00 may be added to your account.
4. **___ ADMINISTRATIVE FEES –** are charged to the following – **FMLA: $75.00; SHORT TERM DISABILITY: $75.00; HANDICAP PARKING PERMIT: $35.00; HUNTING: $35.00; HEALTH FORMS: $3.00 each, DETAILED BILLING STATEMENTS: $1.00 per page, MEDICAL RECORDS:** Fees according to MO Department of Health and Senior Service. We require 3-business days for processing of these forms. Patient must be current on check-up appointments.
5. **___ SELF-PAY PATIENTS –** Payment is expected at the time of service.
6. **___ INSUFFICIENT FUND CHECKS –** a **$50.00** fee will be charged to patient's account for checks returned due to non-sufficient funds.
7. **___ BALANCE ON ACCOUNT –** Accounts with balances for 31+ days or more will be subject to a 2% late fee.
8. **___ NON PAYMENT –** Accounts with an outstanding balance for 90+ days will be charged collection fees and forwarded to a third party for collections. All collection fees are the patient's responsibility. **NO ADDITIONAL CONTACT WILL BE MADE BY OUR OFFICE AT THAT POINT.**
9. **___ PRIVACY POLICY –** I have received and had time to review the Notice of Privacy Practices.
10. **___ CONTROLLED SUBSTANCE AGREEMENT/UNDERSTANDING –** I have received and had time to review the Controlled Substance Agreement/Understanding. I have received and reviewed the opioid fact sheets and understand the risks associated with using controlled substances including risk of dependence and/or addiction, withdrawal, overdose, respiratory depression and/or death.
11. **___** I have been informed and fully understand that **Interventional Pain Institute** has partnership and investment interests in the Interventional Pain Center of Chesterfield and Advanced Surgical Center of Sunset Hills.
12. **___** All my questions have been addressed and answered to my satisfaction.
13. ___ I have received and understand the instruction form regarding the importance of stopping my blood thinners for any spinal procedure(s) and the consequences associated with stopping the medication for any spinal procedure(s).
14. ___ I have received the Patient Counseling Guide regarding opioid analgesics.
15. __ I have been informed and fully understand that Interventional Pain Institute and Ramis Gheith, MD hold ownership of Interventional Pain Center of Chesterfield.

ALL FEES STATED IN THIS FINANCIAL AGREEMENT ARE NOT BILLED TO INSURANCE. FEES ARE THE PATIENT'S FINANCIAL RESPONSIBILITY.

I have read and understand the practice's patient financial agreement and agree to be bound by its terms. I also understand and agree that such terms may be periodically amended by the practice.

Print Patient Name **Patient Signature** **Date**

Signature of Person Authorized to Consent **Relationship to Patient** **Patient's Date of Birth**