		304 Insperon Drive Grovetown, GA 30813 Phone: 706-222-4559 Fax: 706-400-6493 info@aviatorpain.com

Financial Policy and Consent

You are financially responsible for the medical services you receive at Aviator Pain & Spine, LLC (hereafter referred to as "APS"). Please carefully review this Financial Policy, initial each section, and sign the agreement to indicate your acceptance of its terms.

APPOINTMENTS

1. **Copayments, Deductibles, and Coinsurance.** Copayments, deductibles, and coinsurance for clinic visits are due at the time of service, in accordance with the carrier's plan. If you are unable to pay at the time of services, APS reserves the right to reschedule your appointment until such time that you are able to make your payment. Deductibles and coinsurances are calculated as an estimate and may be adjusted after treatment based on any changes to services rendered or medications used.

2. **Procedure Prepayment.** APS may collect your payment for a procedure at the time the procedure is scheduled. Your prepayment is an estimate of your expected financial responsibility. We reserve the right to reschedule your procedure until prepayment arrangements have been made. You are responsible for any unpaid balance after your insurance carrier has processed your claim. In the event of overpayment, you may request a refund.

3. **Self-Pay.** If you do not have health insurance, if your health insurance will not pay for services rendered, or if you notify us not to bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule. Payment is due in full at time of service and a receipt will be given.

4. **Missed Appointments, Late Arrivals, and Cancellation.** Missed appointments and cancellations for non-emergencies within 24 hours may result in a $25.00 fee for each incident. The charges are your personal responsibility and will not be charged to your insurance carrier. If you arrive more than 15 minutes late for your appointment, you be may rescheduled to the next available time slot. INITIAL: __________

INSURANCE PAYMENTS

1. **Financial Responsibility.** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment, in full, for all medical services provided. Any charges not paid by the carrier will be your responsibility, except as limited by the Practice's specific network agreement with your insurance carrier, if such an agreement is in place.

2. Coverage Changes and Timely Submission. It is your responsibility to timely inform us of any change to your billing or insurance information. Your insurance carrier places a time limit within which a claim can be submitted on your behalf. If APS is unable to process your claim within this period due to incorrect insurance information or not responding to insurance carrier inquiries, you will be responsible for all charges. INITIAL: __________

BENEFITS AND AUTHORIZATION

1. **Insurance Plan Participation.** APS has specific network agreements with many insurance carriers, but not all. It is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your plan. Your insurance carrier's plan may have out-of-network charges that have higher deductibles and copayments, which you will be responsible for.

2. **Referrals.** Referral and prior authorization requirements vary among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by APS, it is your responsibility to obtain this referral prior to your

appointment. Without a referral, you will hold financial responsibility for the visit and subsequent services rendered. Although, your referring health care provider, and APS, are expressly permitted to disclose your Protected Health Information (PHI) for your treatment, under HIPAA, you have the right to request restrictions on the disclosure of your PHI. Under HIPAA, APS is not required to agree with you. As a matter of course, APS will inform your referring physician of your patient care plan and progress either by using any secure electronic transmission or via direct communication by an APS employee.

3. **Prior Authorization and Non-Covered Services.** APS may provide services that your insurance carrier's plan excludes or requires prior authorization. APS, as a courtesy to our patients, will make a good-faith effort to determine if services we provide are covered by your insurance carrier's plan, and, if so, determine if prior authorization for treatment is required. If prior authorization is required, we will attempt to obtain such authorization on your behalf. Ultimately, it is your responsibility to ensure that service provided to you are covered benefits and authorized by your insurance carrier.

4. **Out-of-Network Payments and Direct Insurer Payments.** You are personally responsible for all charges. If we are not part of your insurance carrier's network (out-of-network) or your insurance carrier pays you directly for services rendered, you are obligated to forward the payment to APS immediately. INITIAL: __________

ACCOUNT BALANCES AND PAYMENTS

1. **Reassignment of Balances.** If your insurance carrier does not pay for services within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving and initial statement.

2. **Collection of Unpaid Accounts.** If you have an outstanding balance over 90 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney for collection. This may result in adverse reporting to credit bureaus and additional legal action. APS reserves the right to refuse treatment to patients with outstanding balances over 30 days old. You agree, in order for us to service our account or to collect any amounts you owe, we may contact you at any telephone number associated with your account, including cellular numbers, which could result in charges to you. We may also contact you by text message or e-mail. Methods of contact may include using pre-recorded voice messages or use of an automatic dialing device. INITIAL: __________

3. **Returned Checks**. You will be charged a service fee of $25.00 for all returned checks.

4. **Refunds.** Refunds for overpayment are processed only after full insurance reimbursement of all medical services has been received. Please submit a written refund request and allow 6 weeks for your request to be processed. Send requests to: Aviator Pain & Spine, LLC. 304 Insperon Drive, Grovetown GA 30813

5. **Statements.** Charges shown by statement are agreed to be correct and reasonable unless protested in writing within 30 days of receipt. INITIAL: __________

ADDITIONAL FEES

1. Medical Records Requests. The Privacy Rule allows you to receive a copy of your personal medical records, billing records, and allows APS to require individuals to complete and sign an Authorization for Disclosure and Release of Medical Records Form. However, if you are unable to come into the office, APS will make every accommodation to fulfill your request. A minimum processing fee of $25.00 will apply. INITIAL: _________

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3. **Other Forms.** The Practice will respond, at the provider's discretion, to requests for the completion of certain medical forms (FMLA, Short Term Disability, Temporary Disability Parking Permit, etc.) assuming the patient is in good standing and has been active with APS for 6 months consecutively. The charge will be $25 to complete FMLA/disability, and $10 for parking permit applications. Other forms not listed may be considered for completion by APS. In these cases, a fee will be determined by the Office Manager. All requests require an office visit.

INITIAL: ________

4. **Notice of Privacy Practices & Statement of Patient's Rights.** A copy of the Notice of Privacy Practices and Statement of Patient's Rights is available upon request from the front desk and can be downloaded on our website: www.aviatorpain.com. By initialing this section, I acknowledge that I have received a copy of the practice's Notice of Privacy Practices and Statement of Patient's Rights. INITIAL: __________

PRACTICE CODE OF CONDUCT

We are pleased to serve you and glad that you chose Aviator Pain & Spine as your pain management provider. We will always strive to provide exceptional care for you. Reasons that APS may ask you to seek health care services elsewhere might include:

• Rude or violent behavior to staff via in-person or telephone encounters. This also applies to your family members and/or friends

• Repeated no shows, cancellations, or continual late arrivals for office visits or procedures as this adversely limits our availability and care for other patients

• Refusal to adhere to the plan of care as outlined by your clinician or to follow health insurance or government guidelines

• Failure to adhere to the Opioid / Pain Management Agreement (separate document)

INITIAL: __________

AGREEMENT AND ASSIGNMENT OF BENEFITS

I have read and understand the Financial Policy and Consent of Aviator Pain & Spine, LLC, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to APS. I understand that I am financially responsible for all services I receive from APS. This financial policy is binding upon me and my estate, executors and/or administrators, if applicable.

Printed Name: ____/Signature:____________________________________

If patient is minor, Guardian's Printed Name:____________________________Signature:___________________________

Date: __________________