



YOUR INSURANCE COMPANY AND OUR OFFICE

What you need to know about getting your healthcare services paid

Dear Patient/Parent/Guardian:

Auburn Pain Specialists, LLC will file your insurance claim, but you are ultimately responsible for paying for services received in this office. Many of the services provided in this office are covered and paid by your insurance company. We gladly file the claims for you so that you do not have the additional worry and effort of dealing with this during a time of illness.

Unfortunately, not all services are paid by the insurance company. In cases where the service had not been paid, you will be personally responsible for the bill. Before we bill you, we will make sure that all of the information sent to the insurance company is accurate and clearly describes the services you received.

Recent Federal laws addressing all insurance companies require that we submit every claim to an insurance company accurately, reporting the exact services performed and the exact reason for performing them. We are no longer allowed to change this information just so the claim can be paid by the insurance company.

Our practice is committed to these new laws, and will submit all claims to all insurance companies in this manner.

In summary:

- Insurance companies do not pay for all medical services, even those that might be helpful to the patient.
- You are responsible for paying co-pays at the time of the visit.
- When a service is not covered by your insurance policy, you will be responsible for paying the bill.
- We cannot change information on an insurance claim just so that the claim will be paid.
- If you are not sure if a service is covered by your plan, we will be glad to call your insurance company in advance to see if you are going to be responsible for the bill.

If you have any questions, please feel free to ask our office staff.



ASSIGNMENT OF **BENEFITS** FORM

Please initial

_____ **Authorization to Release Information**

I hereby authorize Eric P. Robinson, M.D. to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of lifetime. This order will remain in effect until revoked by me in writing. A photocopy of this Authorization is to be considered as valid as the original.

_____ **Assignment of Benefits**

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medicaid, private insurance and any other health/medical plan to issue payment check (s) directly to Eric P. Robinson, M.D. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. A photocopy of this assignment is too considered as a valid as the original.

_____ I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related **MEDICARE** claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. **Regulations pertaining to MEDICARE assignment of benefits apply.**

Patient Name (Print)

Patient Signature

Witness

Date



OUR FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

- Payment is due at the time of the service unless arrangements have been made in advance. We accept Visa, MasterCard, and Discover.
- Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor. In other words, you agree to have your insurance company reimburse the doctor directly. If your insurance company does not reimburse the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
- We have made prior arrangement with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to co-payment at the time of your visit. As a participating provider, we are required to collect co-pays and deductibles assigned by the carrier.
- If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges will be due at the time of service.
- Not all insurance plans cover all services. In the event your insurance plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your insurance company for all services that we provided at the hospital. You will be responsible for any balance due. You will receive a separate bill from the hospital for the facility fee.
- A charge of \$30 will be assessed for each returned check event to cover the corresponding bank charge and related costs.
- If your insurance requires a referral, a written referral from your primary care physician must be obtained prior to your visit. It is the patient’s responsibility to make sure that referral is already in our office the day of the scheduled visit. If an authorization is not on file prior to the scheduled visit, the patient may be responsible for a higher deductible and co-pay as specified in their contract.
- Worker’s Compensation patients must have an approval obtained from their Worker’s Compensation carrier. Responsibility for payment is the obligation of the patient being treated. If payment has not been received from the insurance/employer, the charges will be your responsibility.

- Medicare: Accepting Medicare assignment means that a physician has agreed to receive a pre-set amount for services rendered. Currently, all patients are responsible for a \$162 annual deductible and a 20% co-insurance for each service. Medicare regulations require that provider collect the co-insurance and deductible amounts from either the patient or their secondary insurance carrier.
- If you miss your appointment, and did not provide us with a 24 hour notice, it will be considered a “No Show” unless your absence is due to a serious emergency. After your second “No Show” a charge of \$50 will be applied to your account. If you fail to contact our office a third time, a charge of \$50 will be applied to your account, and you will be discharged from our practice. Your primary care physician will be notified of your dismissal. If you are scheduled for a procedure and do not notify us, a charge of \$75 will be added to your account. If a second “No Show” occurs for a procedure, your \$75 will be added to your account AND you will not be placed back on the Procedure Schedule.

I have requested medical services from Eric P. Robinson, M.D. On behalf of myself and /or my dependents, I understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. Should my account be turned over to an outside collection agency, I will be responsible for any and all additional fees, charges or expenses incurred by Eric P. Robinson, M.D. for collection of my outstanding account. I understand that Collection Agency Fee, State Sales Tax, Attorney Fees and/or Court cost may be added to my account prior to placement.

Patient Name (Print)

Patient Signature

Witness

Date



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I _____ authorize: _____ to
release copies of my Medical Records to the following:

Auburn Pain Specialists
Eric P. Robinson, M.D.
890 North Dean Rd. Suite 100
Auburn, AL 36830
Phone: (334) 501-2005 Fax: (334) 501-2055

Purpose or need for information: Continuity of care

Patient Name: _____ DOB _____

Address: _____ City _____ State _____ ZIP _____

Phone Number: _____

Release record for the period from _____ to _____

Or

Specify records to be released _____

Please be aware that there may be a charge from your previous physician's office for this service.

I understand that the information to be released may include diagnosis, evaluation and/or treatment for alcohol and/or drug abuse; records of HIV and other STD tests and treatment; and psychiatric/psychological records or evaluation including treatment for mental, physical and/or emotional illness. If you do not wish to have the above information released, please initial here _____

I also understand that this Authorization shall remain valid unless revoked, but will expire in 90 days after signing. I have a right to inspect a copy of the health information to be released and if I do not sign the Authorization, the institution named above will not release my health information except in instances defined in the Joint Notice of Privacy Practices.

Signature of Patient: _____ Date: _____

Signature of Guardian: _____ Relationship _____

Witness: _____



ACKNOWLEDGE OF RECEIPT OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your right under the law. You have the right to review our notice before signing this consent. The terms of our Notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing signed by you. However such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The Patient Understands That:

Protected health information may be disclosed or used for treatment, payment or health care operations.

- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to view this notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by:(Print Name)_____

Relationship to Patient (if other then patient):_____ Date: _____

WITNESS: (OFFICE STAFF PERSONNEL)_____

Acknowledgement of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date below to acknowledge that you have received Our Notice of Privacy Practices.

Signature of Patient or Legal Representative: _____

Name (print):_____ Date: _____

Reason notice not given:_____



PERMISSION TO DISCLOSE RELEVANT HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN MY HEALTHCARE

I GIVE PERMISSION for **Auburn Pain Specialists, LLC** to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual (s) I have listed below who are involved in my health care:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

I DO NOT GIVE PERMISSION for **Auburn Pain Specialists, LLC** to disclose relevant health information (my health status, treatment, and payment arrangements) to family members and other individual involved in my health care.

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Patient's Signature: _____ **Date** _____

Patient's Printed Name: _____

Signature of Witness: _____

Patient is a minor (____ years of age) *OR is unable to give permission because:

Signature of Individual Signing on Patient's Behalf _____ **Date** _____