WOOSTER PAIN AND ANESTHESIA CENTER, LLC

Maher Jeffrey Zackary, MD, MB, BCh

and

Lisa Prebish, NP

WE TREAT YOU LIKE FAMILY

3373 Commerce Parkway, Suite 3
Wooster, Ohio 44691

Phone: (330) 439-4656 Website: woosterpaincenter.com
Fax: (888) 833-4132, (330) 601-0081
Email: wpac@woosterpaincenter.com

Authorization to Release Medical Records

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **PLEASE REVIEW CAREFULLY.**

I authorize the office of **WOOSTER PAIN AND ANESTHESIA CENTER, LLC** to: Send or Obtain my medical records to/from the following physicians or facilities below:

1. ______________________________ 4. ______________________________
2. ______________________________ 5. ______________________________
3. ______________________________ 6. ______________________________

The medical records and data pertaining to:

______________________________ ______________________________
Patient Name: Social Security:

______________________________ ______________________________
Street Address: Date of Birth:

______________________________ ______________________________
City, State, Zip Code Phone Number:

Please specify what records should be released:

- ❑ Initial Consultation and Last 2 Clinic Notes
- ❑ MRI, CT, and X-rays ❑ Labs, Toxicology (e.g. UDS)
- ❑ Discharge letter ❑ Other:________________

Fax Records to (888) 833- 4132 or (330) 601-0081

Do we have your permission to:

Send appointment reminders to your home? Y or N
Send test results to your home? Y or N

Do we have permission to leave the following on your home answering/voice mail:

Appointment information Y or N

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Billing information Y or N
Medical information (ie: Lab/MRI/X-rays results) Y or N

I give permission to share appointment, billing and medical information with the person(s) named below:

Name:__________________________________ Relationship: ___________
Name: __________________________________ Relationship: ___________

Revocation: I understand that I may revoke this authorization at any time by sending a written notice **WOOSTER PAIN AND ANESTHESIA CENTER, LLC** However, the revocation will not have any effect on any uses or disclosures **WOOSTER PAIN AND ANESTHESIA CENTER, LLC** may have made before the revocation was received.

Expiration: I understand that unless I revoke this authorization earlier, this authorization will expire 12 months automatically after the date this authorization is signed. I understand that if I choose to add anyone else to this list I must sign another release form and that your office will not add any additional persons

Re-disclosure: I understand that the information used or disclosed in accordance with this authorization may no longer protected by federal law, and could be disclosed by the receiving party.

Refusal to sign: I understand that I may refuse to sign this authorization and that **WOOSTER PAIN AND ANESTHESIA CENTER, LLC** will not condition treatment on whether I sign this authorization.

Patient/Guardian Signature: ________________________________ Date: ___________

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FINANCIAL POLICY

Your health is our care. Thank you for selecting the **WOOSTER PAIN AND ANESTHESIA CENTER, LLC** as your health care provider. We know you have many choices when it comes to your healthcare and we appreciate the opportunity to care for you. We are committed to delivering outstanding healthcare. Please take some time to read this policy and contact our Billing Office with any questions. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment.

We **cannot** waive co-payment, deductibles, co-insurance or non-covered service amounts defined as patient responsibility under the terms of our contract with the various health plans. Payment of co-payments and co-insurances are due at the time of the office visit. Please be ready to make payment on the day you visit the office.

We require you to make your payment at the time of service so that we do not have to send you a bill. If you have a deductible that has not been met, your insurance carrier will apply services to that deductible.

If you have insurance coverage, we are glad to help you receive maximum allowable benefits and will file your claim(s) for you. If your insurance carrier fails to process your claim within 45 days from the date of service, the balance becomes your responsibility. If an insurance problem occurs, you are asked to assist us in contacting your insurance carrier.

Please be aware that few insurance companies attempt to cover all medical costs. Some companies pay fixed allowances for each procedure/service, while others pay only a percentage of the costs. Our practice is committed to providing the best treatment to you and we charge what is usual and customary for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates, which may bear no relationship to the current standard, and cost of care in this area.

You are responsible for obtaining the necessary referral, if required by your insurance company and bringing the completed form to your appointment. In the event that you are seen without the proper referral/authorization as required by your insurance carrier, you will be responsible for payment of all fees at the time of service. We will file a claim with your insurance carrier and reimburse you if they issue payment to us.

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We ask that you participate in any dispute with your insurance carrier regarding your policy guidelines and regulations

Statements will be mailed monthly and are due for payment within 30 days. Monthly statements will follow until the account is paid in full. If you have not paid your bill, or have not set up a payment plan within 90 days, we will ask for the assistance of a collection agency.

Returned checks and balances referred to outside collection services are subject to additional fees. In addition, patients whose accounts have been referred to collection agencies must pay any outstanding balance and pay for each visit in full at the time of the appointment before additional services/care will be provided.

Our staff is available to answer questions relating to how your claim was filed or any additional information the carrier may need to process your claim. However, your employer or group plans administrator best addresses coverage issues. Your insurance policy is a contract between you and your insurance carrier. The **WOOSTER PAIN AND ANESTHESIA CENTER, LLC** is not a party to that contract and cannot act as a mediator with the carrier or your employer.

Methods of Payment
Cash, personal check, Visa, MasterCard or Discover are accepted methods of payment by **WOOSTER PAIN AND ANESTHESIA CENTER, LLC.**

Past Due Accounts
All patient-responsible balances that remain delinquent after 120 days, with no response to our requests for payment, may be referred to a collection agency. Once an account is turned over to the collection agency, the patient or responsible party will have to settle the debt with the agency. Please be aware that if a balance remains unpaid, you and/or your immediate family members may be discharged from **WOOSTER PAIN AND ANESTHESIA CENTER, LLC** If this is to occur, you will be notified by regular and mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis. It is your responsibility to inform us of any changes in your insurance, telephone numbers, and address. Please have your insurance card available at all office visits

COMMERCIAL INSURANCE PATIENTS:

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Patients will be informed when they make their appointment of the fee range, when possible, for their office consultation. Patients are responsible at the time of service for any co-pay that they may have per their contract with the insurance company. The office will file their commercial insurance claim for them. Any approved amount not paid (i.e. deductible, co-pay, out of pocket) will become the immediate responsibility of the patient.

REFERRALS-HMO AND POS PLANS:

You are responsible for obtaining an authorization for examinations and treatments if required by your insurance company. Often separate referrals will be required for examinations, diagnostic tests, and procedures. Though we may attempt to assist you in obtaining a referral as a courtesy, it is your responsibility to have authorization on file with us before your visit. Without this the insurance company will not pay for your visit. Without a referral you have the option to receive services on a fee for service basis.

SELF PAY PATIENTS:

The full cost of the office visit will be due at the time of service.

MEDICARE PATIENTS WITHOUT SUPPLEMENTAL COVERAGE:

Patients will be informed at the time they make their appointment of the policy regarding Medicare and if possible, the fee range, plus any additional anticipated charges. **Any unpaid deductible, plus the 20% co-pay amount is due at the time of service**. The office will file a claim to Medicare for the balance.

MEDICARE PATIENTS WITH SUPPLEMENTAL COVERAGE:

Patients will be informed at the time they make their appointment of the policy regarding Medicare and if possible, the fee range, plus any additional anticipated charges. The office will file a claim to both to Medicare and the supplemental carrier for all charges. **Any approved amount not paid will become the immediate responsibility of the patient.**

SURGERY CENTER CHARGES:

If your physician recommends surgery, you will meet either in-person or by telephone with a Surgery Center Counselor who can answer specific questions about the surgery scheduling process, discuss paperwork and tests involved, and complete all per-certification/authorization if your insurance company requires it. It is important to note that the Surgery Center is a separate entity and that it will bill you separately from the physician practice. You may be asked to make payment of any co-insurance and deductibles prior to your surgical

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encounter. The Surgery Counselor will explain the cost estimate and your financial responsibility based on your coverage levels and benefits of your plan.

FORMS:
Insurance covers only your medical care. It does not cover submitting forms that may assist you in collecting disability benefits or maintaining employment or handicap permit for parking. Our fee for these services is ($25.00 per page) reflects the resources diverted to the effort.

RETURNED CHECKS:
There will be a $25.00 charge for all returned or canceled checks.

RELEASE OF MEDICAL RECORDS:
There will be a charge for any medical records you need for your records. It will be .10 cents per page or 25.00 for over 20 pages.

If you have any questions, please feel welcome to contact our billing department at your convenience. Your health is our care.

I have read the above Financial Policy and agree to its terms and conditions.

____

Patient Name (please print)

____ ____________________

Signature of Patient or Responsible Party Date

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Authorization for Filing and Collecting Insurance Claims

I,______________________________ a patient of **WOOSTER PAIN AND ANESTHESIA CENTER, LLC** authorize the release of any medical or other information necessary to process any such claims related to my care under this institution. I also request payment of government benefits either to myself or to the party who accepts assignment for my medical care. In addition, I authorize payment of medical benefits to the caring physician at the **WOOSTER PAIN AND ANESTHESIA CENTER, LLC** for services rendered.

Responsible Party for Payment of Account (if other than patient):

First: ____________ Middle:____________ Last:____________

Address:____________________________, City____________, OH ZIP____________

Responsible Party's Date of Birth: ___/___/___

Responsible Party's Social Security Number: ____/___/____

Relationship to Patient: ____________

____
Patient Name (please print)

______________________________ ________________
Signature of Patient or Responsible Party Date