



## Payment Policy

Thank you for choosing Nexus Paincare; we are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

**Billing.** Nexus Paincare has contracted billing services with CE Medical in Salt Lake City, Utah. Any and all insurance and billing questions must be directed to them at (800) 909-9220, option 5.

**Methods of payment.** Our practice accepts the following methods of payment: cash, personal checks, and most major Credit Cards. We also have outside financing available upon request. Checks returned to our office by your financial institution will incur a \$25.00 fee, which is added to your account balance.

**Balances.** You are expected to pay your balance in full within 30 days. Should special circumstances arise, we would ask that you contact PhyLogic to explain those circumstances.

**Insurance.** Nexus Paincare will bill your insurance company as a service to you as long as you have provided complete and accurate information. Having an insurance policy does not guarantee payment. You are responsible for all incurred charges. We participate with most insurance plans. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility; you are responsible for confirming your coverage based on your individual plan. If your insurance plan requires a referral you will be responsible for obtaining a current referral for each visit. Please contact your insurance company with any questions you may have regarding your coverage. Should your insurance reject your claim for any reason, you are financially responsible for all incurred charges. That is, if your insurance denies payment you agree to be personally and fully responsible for payment.

**Co-payments, deductibles, and self-pay.** If you have not met your deductible or if your insurance requires a co-pay or patient responsibility percent, these amounts will be due at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. If you do not have health insurance (self-pay patients), you will be required to pay in full for all services at the time they are received.

**Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

**Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us

with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

**Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

**Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full or to make arrangements to pay it off in 3 months. Partial payments will not be accepted unless otherwise negotiated. If your account goes delinquent, you agree to pay processing fees, interest at the rate of 18% annually on all past due balances from the original due date, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee if the account is assigned to a collection agency.

**Missed appointments.** Our policy is to charge for missed appointments not canceled within 24 hours of scheduled appointment. A missed appointment fee will be your responsibility and billed directly to you. This fee will need to be paid at your next scheduled appointment. Please help us to serve you better by keeping your regularly scheduled appointment.

**Accurate information.** You must supply Nexus Paincare with accurate information regarding your address, phone number, and insurance information. Promptly notify of us of any changes.

**Agreement.** I, the undersigned, acknowledge that I have read and understood this account policy. I agree to make payments to Nexus Paincare according to the above terms. I authorize my insurance carrier to send payments directly to Nexus Paincare according to the above terms and on my behalf. I also agree that in the event my account goes delinquent that I will pay processing fees, interest at the rate of 18% annually on all past due balances from the original due date, plus collection fees if my account is assigned to a collection agency.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

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**Signature of Responsible Party**

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**Date**

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**Printed Name**