4024 Park East Court SE
Suite C
Grand Rapids, MI 49546
616.975.1186 (ph)
616.975.0467 (fax)

20095 Gilbert Road
Suite B
Big Rapids, MI 49307
231.592.1360 (ph)
231.592.1361 (fax)

NEW PATIENT PACKAGE – INFORMATION, INSTRUCTIONS, QUESTIONNAIRE

Dear New Patient:

YOUR APPOINTMENT
DATE
TIME
LOCATION

Welcome to our practice! We look forward to becoming a part of your healthcare team. Enclosed are some specific details, instructions, and a general questionnaire. We appreciate that you take the time to carefully read and understand the instructions, as well as complete the questionnaire.
Doing so allows us to provide the most appropriate treatment. Should you have any questions, comments, or concerns, please feel free to contact the office at 231-592-1360 or 616-975-1186.

YOUR APPOINTMENT

We will contact you prior to your appointment to confirm the date, time, and place of your appointment. If you are unable to be reached during regular business hours, please contact the office at 231-592-1360 or 616-975-1186.

- to confirm your appointment.
- If for any reason you wish to reschedule or cancel your appointment, please contact our office with at least **48 hours notice**.
- Please arrive **15 minutes early** for office registration.
- **If you are currently involved in litigation (the suing process) with regard to AUTO or WORKERS' COMPENSATION claims, please contact our office prior to your visit. <u>Please bring your adjustor's name, telephone number, and claim number to your appointment.</u>**
- **Prior to your appointment**, please complete the enclosed forms to the best of your ability. Please bring the completed forms with you to your appointment.

DIRECTIONS TO OUR LOCATIONS

<u>West Michigan Pain – Big Rapids</u> **20095 Gilbert Road, Suite B, Big Rapids, MI 49307** US-131 exit 139 – Perry Street. Turn East onto Perry St and continue past Wal-Mart to State Street (2 Miles). Turn South on State Street, drive 1 mile and turn right (West) onto Gilbert Road. The office is on the left-hand side.	**<u>West Michigan Pain – Grand Rapids</u>** **4024 Park East Court SE, Suite C, Grand Rapids, MI 49546** I-96 exit 40 – Cascade Road West. Drive for .5 miles. Turn South onto East Paris. Drive 1.5 miles on East Paris. Turn left onto Park East Court. Our office is located in the same building as Chemical Bank.
<u>West Michigan Pain – Reed City</u> **22018 Professional Drive, Reed City, MI 49677** US-131 exit 153 – US-10. Head East on US-10 and take first right onto 220th Ave. Continue for .6 miles. The office is on the right, across from Reed City Hospital.	**<u>West Michigan Pain – Cadillac</u>** Located on the 4th floor of the Munson Healthcare Cadillac Hospital **400 Hobart St, Cadillac, MI 49601** US 131 exit 177- Turn onto US131 Business route (Heading North towards Cadillac). Drive 1.92 miles and turn *right* onto Cobb St, then slight left onto Hobart St. hospital is on your right just past Lynn St.

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CONSENT TO BILL INSURANCE

Please read the following information and sign below. If you have any questions, please ask a customer care specialist.

Assignment of Insurance Benefit

I hereby authorize payment directly to Michigan Primary Care Partners, PC the benefits payable to me, but not to exceed the balance of the charges for this event. All co-pays and deductibles are due prior to the time of treatment. I agree that the information presented on this form is true and accurate.

Financial Responsibility

I understand that I am financially responsible to Michigan Primary Care Partners, PC for any amount not covered by this authorization. The insurance policy is a contract between my insurance company and me. A claim will be filed with my insurance carrier within 45 days. If payment is not made by the insurance carrier within 45 days of filing, the balance will automatically transfer to the responsible party account. Payment by the responsible party is expected within 10 business days of notice of insurance non-payment. In the event that this account is placed with an attorney or collection agency, the undersigned is responsible for collection fees, reasonable attorney's fees, and court costs.

Authorization

I hereby authorize release of my medical record information necessary to process insurance claims. I authorize Michigan Primary Care Partners, PC to issue a complaint to the insurance commissioner for any reason. I further authorize the release of medical information to those healthcare facilities and/or physicians who may be responsible for the patient's care. I understand that it may be necessary to test the patient's blood to protect against possible transmission of blood-borne diseases such as Hepatitis B or Acquired Immune Deficiency Syndrome (AIDS) if, for example, an employee or physician is stuck by a needle or sustains a scalpel injury during the performance of care. I understand and consent that the patient's, as well as the employee's or physician's blood, will be tested as is appropriate. I further understand that routinely tested blood results and tests for those diseases mentioned will be kept confidential in accordance with state law.

Date	Patient's Printed Name	Signature (Patient or Legal Guardian)
Date	Witness Signature	Witness Relationship

Receipt of Privacy Notice

I acknowledge that I have received notification in regards to the Health Insurance Portability and Accountability Act (HIPAA) and have access to a copy of the written Joint Notice of Privacy Practices.

Date	Patient's Printed Name	Signature (Patient or Legal Guardian)

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DEMOGRAPHIC INFORMATION

Please answer the following questions completely. If a question does not apply, please write not applicable.

_____ _____ _____/_____/_____
First Name Last Name Date of Birth

_____
Address

_____ _____ _____ **Social Security Number** _____-____-_____
City State Zip

_____ _____
Home Phone Initial

_____ _____
Cell Phone Initial

_____ _____
Work Phone Initial

_____ _____
E-mail Address Initial

_____
Emergency Contact Details – Full Name, Telephone Number(s)

In some cases, it may be necessary to leave messages that may contain your medical or personal information. Please initial above after any number where we may leave messages.

Primary Care Physician

_____ _____
Physician Name Phone

Referring Physician

_____ _____
Physician Name Phone

Insurance Information

_____ _____
Primary Insurance Name ID #

_____
Insured Name and Date of Birth

_____
Relationship to Patient

_____ _____
Secondary Insurance Name ID #

_____
Insured Name and Date of Birth

_____
Relationship to Patient

Auto or Work Injury

Auto Injury? □ **Yes** □ **No**
If yes, date of accident:
_____

Work Injury? □ **Yes** □ **No**
If yes, date of accident:
_____

Is your claim in litigation?

□ **Yes** □ **No**

_____
Adjustor Name

_____
Adjustor Phone Number

Printed Patient Name: _____ **Date:** _____

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AUTO INJURY FORM

If you are seeing us for an injury arising from an automobile accident, please complete the form below.

Accident Details

Date of automobile accident: _____ I was wearing a seatbelt: □ **Yes** □ **No**

I was the: □ **Driver** □ **Front Passenger** □ **Rear Passenger** □ **Pedestrian**
□ **Other** _____

I was in a: □ **Car** □ **Truck** □ **Van** □ **Motorcycle** □ **Other** _____

Please describe the accident (in detail): _____

_____

_____

The accident occurred: _____ am/pm **Location**: _____

Other vehicle: □ **Car** □ **Truck** □ **Van** □ **Motorcycle** □ **Other** _____

The weather was: □ **Clear** □ **Foggy** □ **Raining** □ **Snowing** □ **Other** _____

The road conditions were: □ **Dry** □ **Wet** □ **Icy** □ **Other** _____

During the accident, I was: □ **Looking Forward** □ **Looking Backward** □ **Looking to the Side**
□ **Using the Rearview Mirror** □ **Other** _____

I was prepared / braced for the accident: □ **Yes** □ **No**

During the accident, I struck the following objects inside the vehicle: □ **None** □ **Chest – Steering Wheel**
□ **Knee – Dashboard** □ **Head – Windshield** □ **Shoulder – Door** □ **Other** _____

Following the accident, I was: □ **Fine** □ **Dazed** □ **Dizzy** □ **Unconscious** □ **Angry**
□ **Other** _____

For how long? _____

My vehicle was damaged: □ **Front** □ **Rear** □ **Driver Side** □ **Passenger Side**
Approximate damage in dollar amount: _____dollars

My vehicle was drivable after the accident: □ **Yes** □ **No**

I left the scene of the accident by: □ **Ambulance** □ **My Vehicle** □ **Other** _____

My occupational title and job duties at the time of injury were: _____

_____

I am currently working: □ **Yes** □ **No** With restrictions: □ **Yes** □ **No**
Please describe any current restrictions: _____
I am doing the same job duties as before the injury: □ **Yes** □ **No**
The last date that I worked was: _____ Still working? □ **Yes** □ **No**
I lost time from work: □ **Yes** □ **No** From _____ to _____ due to my injury
I am working for a different employer: □ **Yes** □ **No**
Name of new employer: _____

Printed Patient Name: _____ **Date:** _____

G

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WORK INJURY FORM

If you are seeing us for a WORK-RELATED injury or illness, please complete the form below.

Date of work-related injury: _____

My employer at the time of injury was: _____

I reported my injury to: _____

Please describe what happened: _____

_____

_____

My occupational title and job duties at the time of the injury/illness were: (please describe in detail)

_____

_____

_____

The heaviest weight that I lifted was: _____ pounds _____ times per day

I began working for this employer: _____ (month) _____ (year)

An employment physical was done at the time I was hired: □ **Yes** □ **No**

Did you like the job you were doing? _____

Did you like your work environment? _____

At the time you got hurt were you doing your usual work? (please describe if you were doing a different job)

_____

_____

I began this work with restrictions: □ **Yes** □ **No** **Type:** _____

I am currently working: □ **Yes** □ **No** With restrictions: □ **Yes** □ **No**

Please describe any current restrictions: _____

I am doing the same job duties as before the injury: □ **Yes** □ **No**

The last date that I worked was: _____ Still working? □ **Yes** □ **No**

I lost time from work: □ **Yes** □ **No** From _____ to _____ due to my injury

I am working for a different employer: □ **Yes** □ **No**

Name of new employer: _____

Describe your new job: _____

Do you want to return to the same job? □ **Yes** □ **No** If "no", then why? _____

_____

Are you able to do any type of job right now? □ **Yes** □ **No**

_____

_____

Printed Patient Name: _____ **Date:** _____

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PATIENT'S CHIEF COMPLAINT

Please tell us about your chief complaint – the issue for which you are seeking health care.

Chief Complaint / Location of Pain

example: Low back pain

_____

History of Present Illness

Please describe how long you have been having pain or discomfort and if you can recall any injury to the area.

_____

_____

_____

_____

Is your pain getting worse over time? □ **Yes** □ **No** If yes, how long has it been getting worse? _____

Present Complaints

Where is the pain located? _____

Does your pain radiate to anywhere else in your body? □ **Yes** □ **No** If yes, to where? _____

Is your pain □ **Occasional** □ **Frequent** □ **Constant**

How would you describe your pain? □ **Aching** □ **Sharp** □ **Dull** □ **Stabbing** □ **Cramping** □ **Throbbing** □ **Shooting** □ **Burning**

Would you consider your pain □ **Mild** □ **Moderate** □ **Severe**

Do you experience any numbness and/or tingling? □ **Yes** □ **No** If yes, to where? _____

What makes your pain better? □ **Rest** □ **Medication** □ **Heat** □ **Ice**

What makes your pain worse? _____

Past / Current Treatment

Have you had any of the following treatments or diagnostics in relation to your pain? If so, please tell us where and when.

TYPES OF TREATMENT	DATE(S)	DOCTOR OR LOCATION
□ **Surgery**		
□ **Physical Therapy**		
□ **Chiropractic Treatment**		
□ **Injections**		
DIAGNOSTIC STUDIES / IMAGING	**DATE(S)**	**DOCTOR OR LOCATION**
□ **EMG**		
□ **Bone Scan**		
□ **MRI**		
□ **CT Scan**		
□ **X-RAYs**		
□ **Other** _____		

My current treatment includes:
□ **Medication** □ **Physical Therapy** □ **Chiropractic Treatments** □ **Injections** □ **Surgery Considered**
Are any of these helping? □ **Yes** □ **No** If yes, which ones? _____

Printed Patient Name: _____ **Date:** _____

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MEDICATIONS AND ALLERGIES

Please tell us about any medications that you take and any allergies that you have:

Medications

Name	Strength	Directions
example: L A S I X	40 mg	1 tablet daily

Allergies

Allergies	Allergies
example: S H E L L F I S H	example: I O D I N E

Are you taking any of the following: □ **Aggrenox** □ **Aspirin** □ **Coumadin** □ **Plavix** □ **NSAIDs**

Printed Patient Name: _____ **Date:** _____

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DAST-10

Please answer the following questions:

Have you used drugs other than those required for a medical reason? ☐YES ☐NO

If YES please list drug types _____

Do you abuse more than one drug at a time? ☐YES ☐NO ☐N/A

If YES please list drug types _____

Are you unable to stop abusing drugs when you want to? ☐YES ☐NO ☐N/A

Have you ever had black-outs as a result of your drug use? ☐YES ☐NO ☐N/A

Do you ever feel bad / guilty about your drug use? ☐YES ☐NO ☐N/A

Do your spouse or other family members complain about your drug use? ☐YES ☐NO ☐N/A

Have you neglected your family because of your drug use? ☐YES ☐NO ☐N/A

Have you experienced withdrawal symptoms on stopping drugs? ☐YES ☐NO ☐N/A

Do you have medical problems as a result of taking drugs? ☐YES ☐NO ☐N/A

Additional comments related to your drug use that you wish to share:

_____

_____

_____

_____

Printed Patient Name: _____ **Date:**_____

WMP DAST Form 10/2016

4024 Park East Court SE Suite C
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Fax. (231) 592-1361

Patient History

Fill out as accurately as possible and please ask for assistance if you have questions.

Print Name:_____

Birthdate:___/___/_____ Age:_____

	Yes	No
Anemia (Type: _____)		
Blood clotting problems		
Asthma		
Apnea (Heavy Snoring)		
Are you on CPAP at home?		
Are you on Oxygen at home?		
Emphysema / COPD		
High blood pressure		
Chest pain		
Irregular heart beat		
Heart attack		
Colon/bowel problems		
Diabetes Type 1____ Type 2____		
Ear/nose/throat issues		
Cancer		
Arthritis		
Kidney/Bladder issues or infections		
Gout		
Thyroid		
Migraine headaches		
Seizures		
Stroke		
Rheumatic fever		
Skin disease		
Depression / Anxiety		
MEN: Prostate problems		
WOMEN: GYN problems		
Smoking History Packs/Day___ Years___		
Alcohol History		
Drinks/Week _____		
Recreational drug usage: Types_____		

Social History

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of Children: _____

Current Occupation: _____

☐ Retired

☐ Legally Disability

Family Health History

Major Conditions (I.e. Cancer, COPD, etc.)	
Father	
Mother	
Sister (s)	
Brother (s)	

Past Surgical History

Procedure	Date / Comments / Complications
Tonsillectomy	
Appendectomy	
Thyroid	
Gall bladder	
Heart- bypass	
Any joint?	
Spinal Surgery	
Other Surgery	

Comments / Additional Information:

_____

_____

_____

_____

Patient or Authorized Representative Signature ➡ _____ Date_____

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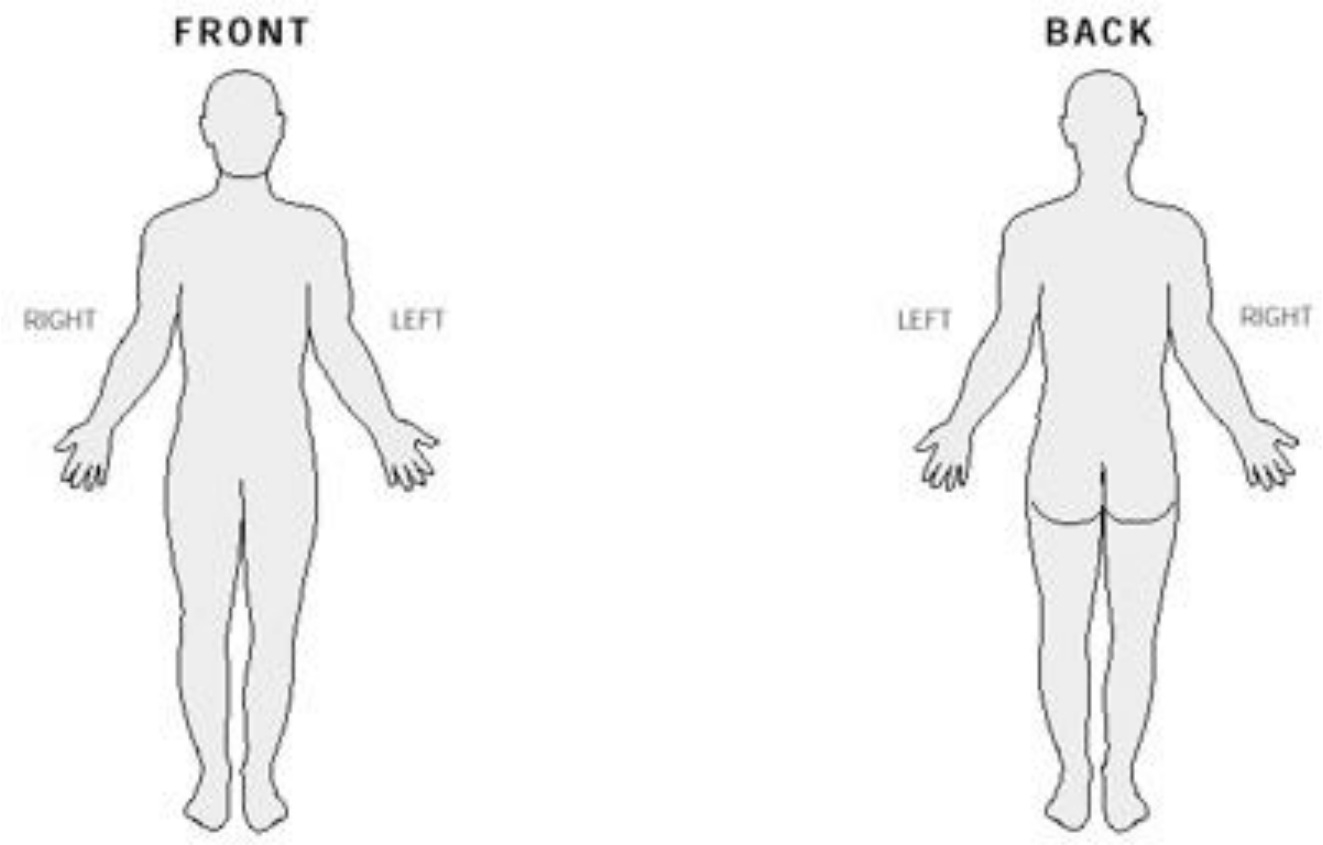
PAIN PROFILE

Where is your pain right now? Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation; be sure to include all affected areas.

Aching	Numbness	Pins and Needles	Burning	Stabbing
A A A	**= = =**	**O O O**	**X X X**	**/ / /**



Please mark a W on your body where the pain is worst right now.

Please circle the number below that best represents your pain. 0 is the least pain, 10 is the most pain.

0 1 2 3 4 5 6 7 8 9 10

Physician: I have reviewed this new patient information. _____

Printed Patient Name: _____ **Date:** _____

Patient Signature: _____

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PAIN PROFILE – ODI QUESTIONNAIRE

Please complete the following questions by circling the number that corresponds to your condition.

PAIN INTENSITY
(0) I have no pain at the moment
(1) The pain is very mild at the moment
(2) The pain is moderate at the moment
(3) The pain is fairly severe at the moment
(4) The pain is very severe at the moment
(5) The pain is the worst imaginable at the moment

PERSONAL CARE (WASHING, DRESSING, ETC)
(0) I can look after myself normally without causing extra pain
(1) I can look after myself normally but it is very painful
(2) It is painful to look after myself and I am slow and careful
(3) I need some help but manage most of my personal care
(4) I need help every day in most aspects of self care
(5) I do not get dressed, wash with difficulty and stay in bed

LIFTING
(0) I can lift heavy weights without extra pain
(1) I can lift heavy weights but it gives extra pain
(2) Pain prevents me from lifting heavy weights off the floor; but I can manage if they are conveniently positioned, e.g. on a table
(3) Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
(4) I can lift only very light weights
(5) I cannot lift or carry anything at all

WALKING
(0) Pain does not prevent me walking any distance
(1) Pain prevents me walking more than one mile
(2) Pain prevents me walking more than ¼ mile
(3) Pain prevents me walking more than 100 yards
(4) I can only walk using a stick or crutches
(5) I am in bed most of the time and have to crawl to the toilet

SITTING
(0) I can sit in any chair as long as I like
(1) I can sit in my favorite chair as long as I like
(2) Pain prevents me from sitting for more than 1 hour
(3) Pain prevents me from sitting for more than ½ hour
(4) Pain prevents me from sitting for more than 10 minutes
(5) Pain prevents me from sitting at all

STANDING
(0) I can stand as long as I want without extra pain
(1) I can stand as long as I want but it gives me extra pain
(2) Pain prevents me from standing for more than 1 hour
(3) Pain prevents me from standing for more than ½ hour
(4) Pain prevents me from standing for more than 10 minutes
(5) Pain prevents me from standing at all

SLEEPING
(0) My sleep is never disturbed by pain
(1) My sleep is occasionally disturbed by pain
(2) Because of pain I have less than 6 hours of sleep
(3) Because of pain I have less than 4 hours of sleep
(4) Because of pain I have less than 2 hours of sleep
(5) Pain prevents me from sleeping at all

SEX LIFE (IF APPLICABLE)
(0) My sex life is normal and causes no extra pain
(1) My sex life is normal but causes some extra pain
(2) My sex life is nearly normal but is very painful
(3) My sex life is severely restricted by pain
(4) My sex life is nearly absent because of pain
(5) Pain prevents any sex life at all

SOCIAL LIFE
(0) My social life is normal and causes me no extra pain
(1) My social life is normal but increases the degree of pain
(2) Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports, etc
(3) Pain has restricted my social life and I do not go out as often
(4) Pain has restricted social life to my home
(5) I have no social life because of pain

TRAVELLING
(0) I can travel anywhere without pain
(1) I can travel anywhere but it gives me extra pain
(2) Pain is bad but I manage journeys over two hours
(3) Pain restricts me to journeys of less than one hour
(4) Pain restricts me to short necessary journeys less than 30 minutes
(5) Pain prevents me from traveling except to receive treatment

ODI = _____%

Printed Patient Name: _____ **Date:** _____

WEST MICHIGAN PAIN
LEADING EDGE | COMPREHENSIVE PAIN SPECIALISTS

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Girish Juneja, MD
Board Certified Pain Management

Mark Clark, MD
Board Certified Pain Management

Melissa Kooistra, PA-C
Pain Management

Maria Benit, PA-C
Pain Management

Dennis Behler, PA-C
Pain Management

Dear Valued Patient,

We are honored that you have chosen us as your healthcare provider. Today we have exciting news regarding your health management!

As we continue in our efforts to provide our patients with the highest quality of care, we are constantly looking for methods of working together with you to ensure that you are not only aware of, but also involved in the management and improvement of your health.

We are proud to inform you that our practice now offers the opportunity to use the power of the web to track the most important aspects of your healthcare through our office. The "Patient Portal" enables our patients to communicate with our doctors, nurses, and staff members easily, safely, and securely *via* the Internet.

Participating patients are given secure User IDs and passwords, enabling them to access the Portal to view their personal and private documents.

The Patient Portal makes it **Easy** for you to:

- **Ask your doctor, nurse, or a staff member a question**
- **Request prescription refills***
- **Request NON-URGENT appointments and view upcoming appointments**
- **Receive appointment reminders**
- **Verify and / or update current medication list**
- **View your personal health record**
- **Examine your current and past billing statements**
- **Receive our monthly e-newsletter**

This can all be done from the comfort and convenience of your home!

Begin today and take an active role in managing your healthcare!

To get signed up today, please fill out the following information and hand to the receptionist when checking in. They will then provide you with a username, password, and website info.

Patient Name: _____ D.O.B. _____

Email Address _____

*Medication refills will be addressed within 1-4 business days.

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Big Rapids, MI 4967
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Fax (231) 592-1361

22018 Professional Dr.
Reed City, MI 49677
Ph (231) 832-1111
Fax (231) 832-1010

4024 Park East Court SE
Grand Rapids, MI 49546
Ph (616) 975-1186
Fax (616) 975-0467

PATIENT FINANCIAL POLICY

As a courtesy to our patients, we bill their insurance carrier(s) for all appropriate medical fees. **However, we require that our patients pay any portion not covered by their insurance, due to deductibles and co-pays, on the day of service.** Health insurance is a contract between the patient and their insurer. Although we file insurance claims as a courtesy to our patients, it is important to remember that the person receiving the services*, the patient*, is ultimately responsible for ensuring that full payment of services is made, regardless of the amount their insurance carrier covers. Failure to provide accurate billing information at the time of service will result in all fees becoming the responsibility of the patient (or legal guardian representing the patient). It is the patient's responsibility to provide their insurance carrier with any requested information needed to process their claim in a timely manner. Failure to provide requested information to a patient's insurance carrier within thirty (30) days of such request will result in all fees becoming the responsibility of the patient (or legal guardian representing the patient).

Balances Due After Insurance Pays: If an account balance remains after your insurance carrier pays, you have 30 calendar days to make a payment on the invoice. Payments not made within 30 days are considered Past Due. Payments not made within 120 days are considered Delinquent.

Collections: Patients who have not attempted to pay their copay, deductible or other (non-insurance covered) amounts totaling $100 or more for a period of greater than 120 days will have billing account information forwarded to an attorney and/or third party collections agency.

Delinquent Accounts and Waiver of Confidentiality: You understand that if your billing account information is submitted to an attorney and/or third party collection agency, if we are required to litigate in court, or if your past-due status is reported to an agency, the fact that you received treatment at our facility may become a matter of public record. In the event of a delinquent account you agree to pay all collection agency fees. You also agree to pay all court fees, the maximum amount of interest allowed by law, and any attorney fees incurred due to your delinquency.

Notice of "Non-Covered" Services: Please review your healthcare policy very carefully prior to receiving services. Once services are rendered, you remain entirely financially responsible for any services performed at this facility that are considered *non-covered* by your insurance carrier.

ASC Deposit Required: If you are utilizing our facility to undergo an ambulatory surgery center (ASC) procedure, we will verify your insurance benefits and obtain appropriate authorizations from your insurance carrier in advance of your scheduled procedure date. Once your insurance carrier determines your deductible, co-payment and/or co-insurance amounts due for your planned surgical procedure, we will collect the full amount of *your* expected financial liability from you, **prior to your planned procedure**. Failure to pay this amount upon arrival to the facility will result in your removal from the schedule on that day.

Cancellations due to insufficient copay/deductible payment at the time of visit: If you fail to pay your copay or deductible at or prior to the time of your visit, and the result is a last-minute cancellation of your appointment, a last-minute cancellation fee of $50 will be posted to your account. This amount, as well as any unpaid copay/deductible amounts on account must be paid prior to additional services being provided.

If You Have:

-Regular Medicare without a Secondary Insurance: Payment of your 20% co-pay is due at the time of your visit.

-Regular Medicare with a Secondary Insurance or Medigap: No payment is due at the time of your visit.

-A Worker's Compensation Claim: Call your carrier ahead of time to verify the accident date, claim number, primary care physician, employer information, and referral procedures. If we have verified the claim with your carrier then no payment is necessary at the time of your visit. If we are not able to verify your claim then payment in full will be required at the time of your visit. If your claim is denied you will be responsible for payment in full.

-A Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require written verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed.

–A Personal Injury (continued): Payment of your bill remains your responsibility. We cannot bill your attorney for charges incurred during your personal injury case. You also realize that we have a lien on any personal injury settlement pursuant to N.C.G.S. 44-49, et seq and you authorize your attorney or liability carrier to pay those lien amounts to us out of any settlement proceeds without further authorization from you.

-Out of Network / Non-Participating Insurance: If we are not in network with your insurance carrier, we will bill your carrier as a courtesy to you. If the balance is not received within sixty (60) days, the balance becomes your responsibility. Please be aware that you may incur more out-of-pocket expenses for receiving medical care out-of-network. You, the patient, will have to contact your insurance company to determine why payment has not been paid. It is your responsibility to check with your insurance carrier for benefit coverage.

-Self-Pay: We require that patients with self-pay balances to pay their account balances to zero ($0) prior to future appointments being made.

Referrals: If your insurance carrier has designated a primary care physician (PCP), you are most likely to have prior authorization from your PCP prior to your visit. If this authorization is not provided at the time of your appointment, you will be required to reschedule.

Maximum Account Balance: If your account balance exceeds $500 (includes copay, deductible or other non-insurance covered amounts) we will not provide additional services until your account balance falls below the $500 balance limit.

Insurance Forms; Medical Records; and Disability Forms: We charge an administrative fee for completing insurance forms, medical records requests; and for completing disability verification forms. Please be aware that these services may require up to 7 to 10 business days to complete.

Transferring Records: You will need to submit a written request and pay a reasonable administrative fee if you wish to have a copy of your medical records for yourself or sent to businesses other that healthcare organizations. Medical records requested and sent to other healthcare organizations will be made available free of charge.

Returned Check Fee: In the event that we receive a returned check, due to insufficient funds, a $35 fee will be charged to your account and additional services will not be provided until your account is paid in full.

Acceptable forms of Payment: For your convenience, we accept cash, check, MasterCard and Visa. We also offer *CareCredit* ™ financing, which is a low-cost financing alternative for medical care. Our billing representatives would be happy to explain these services to you.

Missed Appointment Fees: If you are unable to appear for your appointment, it is your responsibility to contact us well in advance. The following fees may be assessed if you do not contact us to cancel in a timely manner or if you fail to show up for a scheduled appointment without advanced notice.

Late Cancellation:
If you fail to call to cancel by 12:00pm (noon) on the day prior to your scheduled visit, or by 12:00pm on the Friday before a Monday appointment, a **Late Cancellation Fee of** Forty Five Dollars ($45) may be added to your account. This fee is not covered by your insurance company.

No Shows:
This fee is not covered by your insurance company and must be paid prior to future appointments being made.

MPCP / WMP- Patients failing to contact us and not showing up for their scheduled appointment will be charged a Fifty Dollar **($50) No-Show Fee**.

I state that I have read and fully understand the MPCP/WMP Patient Financial Policy and agree to abide by the terms specified above.

_____ _____
Patient or Legal Guardian Signature Date

If guardian signature appears above, please print name and describe Legal Guardian's relationship to the patient: _____ _____

Printed Legal Guardian Name Relationship to Patient