

Comprehensive Pain Management

Michael A. Lepis, M.D.

Medical Billing Department

2420 Highway 34, Manasquan, N.J.08736

Financial Policy

Medicare Financial Policy:

1. After your deductibles have been satisfied, Medicare will pay 80% of allowed charges. If you do not have a secondary coverage as a supplement, you will be responsible for 20% of those charges on the day the services are rendered.
2. Medicare requires that you sign a waiver for each date of service acknowledging that we have explained, to the best of our ability, what is eligible for reimbursement and what is not. This must be signed **Every Visit**.

Commercial Insurance Financial Policy:

1. We need you to understand that your insurance coverage is just that, **your** coverage. It does not release you from any financial obligations for the services we rendered to you.
2. If you are a new patient, or your insurance changes, you must furnish us with a copy of your insurance card prior to treatment. This card should be given to us within a reasonable time so that we can verify coverage and obtain your benefits.
3. Some insurance policies require referral from your primary care physician. It is your responsibility to make sure we have that referral prior to your first date of treatment. Otherwise, you will be held liable, responsible for the balance.
4. If we are unable to verify coverage and/or obtain a proper referral, you will be held responsible for any balance. Upon receipt of referral and/or verification of coverage, we will then file your insurance.
5. We require that you pay co-insurance, deductibles and co-pay at the time of service. A patient's co-pay or coinsurance balance must not exceed \$200.00 or your professional care may be terminated.
6. If for any reason your insurance company has not covered your treatment within 120 days, you will be classified as a self-pay patient for outstanding dates of service.
7. Once **all** insurance payments have been received and it is deemed you have made an overpayment, we will refund any overpayment promptly.
8. If for any reason you should lose your insurance coverage, you will be classified as a self pay patient, but will not exceed 120 days. After that time you will be discharged from our practice.

Miscellaneous Information:

1. We accept cash, debt cards, checks, Visa, MasterCard and Discover.
2. We require that any amount due be paid at the time of appointment. Please call our medical billing department at phone # 732 281 3590. Or you may also send us a fax at 732-223-5726.
3. The fee for a returned check is \$35.00. If you submit a check with insufficient funds, your professional care treatment may be suspended until your balance is paid. Checks will no longer be accepted from a patient who has had a returned check.
4. We require a 24 hour notice if you need to cancel your appointment. The fee for a missed appointment /no show/ less than a 24 hour notice is \$25.00.
5. It is our company's policy that we randomly require our patients to be given a Urine Drug Screening. We will submit the claim to your insurance, but if your insurance denies the claim for non-coverage, you will be held responsible to pay the fee of \$25.00 for UDS.
6. Any patient account balance over 120 days past due, which does not have a financial payment contract, will be turned over to an outside collection agency. This also includes any patient with an account balance who has defaulted from their financial payment contract.
7. Treatment will not be administered to any patient whose balance exceeds \$250.00 without a written and signed financial payment contract.

Patients Name _____ Date _____