David L. Spivey, MD
Medical Director
Board Certified, Pain Medicine

Jeffery A. Adams, MD
Board Certified, Pain Medicine

Chad Caldwell, MHS, PA-C
Michael Roche, PA-C
Pamela Campbell, PA-C

Relieve Pain. Restore Function...Resume Life.

2912 Maplewood Avenue
Winston-Salem, NC 27103
336.760.0706 ph
336.760.1927 fx

1511 Westover Terrace, Suite 107
Greensboro, NC 27408
336.398.5155 ph
336.398.5156 fx

PreferredPainManagement.com

Financial Policy

Thank you for choosing us as your pain management and spine care specialist. We are committed to providing you with quality and affordable health care. This document sets out our financial policies. Please read it, ask us any questions you may have, and sign in the space provided below to acknowledge your understanding and agreement. A copy of this policy will be provided to you upon request.

1. **Insurance Participation.** We participate in many insurance plans, including Medicare, however please be advised that we do not accept retro-active coverage from any insurance company. If we participate in your plan, we will file the insurance claim for you. If you are insured by a plan in which we do not participate, payment in full is expected at each visit. If you are insured by a plan in which we participate 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. If you are insured by a plan with whom we do not participate, it is your responsibility to know your "in network" and "out of network" benefits. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments, co-insurance and deductibles.** All co-payments, co-insurance and deductibles must be paid at the time of service.
3. **Non-covered services.** Please be aware that some of the services you receive may not be covered by your insurance plan or may not be covered by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing any provider. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. We require a copy of your driver's license to reduce the risk of identity theft. 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.
5. **Claims submission.** We will submit your claims and reasonably assist you 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 your charges are 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.
6. **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 benefits. If your insurance company does not pay your claim in 45 days, the balance may be automatically billed to you.
7. **Return Check fees.** A $25.00 insufficient funds fee will be added to your account for any returned check. Please note this charge is in addition to fees associated with your banking institution.
8. **Cancelled appointments.** We require 24-hour notice for canceling any appointments. Please refer to PPMSC Cancellation/No show policy for specific fees.
9. **Nonpayment.** If your account is over 90 days past due, we may refer your account to a collection agency and you will be responsible for all costs and expenses of collection including, but not limited to, our reasonable attorney's fees. Non-payment may also result in your discharge from this practice. If this is to occur, you will be notified in writing 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.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY AND AGREE TO ITS TERMS.

_______________________________	_______________________
Signature of patient or responsible party	Date
_______________________________	_______________________
Printed Name	Date of Birth