

DOLORA PAIN MANAGEMENT ASSOCIATES, P.C.

12434 E. 12 Mile Rd., Suite #203, Warren, MI 48093

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FINANCIAL POLICY

1. PAYMENT IS **DUE** AT THE TIME OF SERVICE. THIS INCLUDES **ALL** CO-PAYS AND DEDUCTIBLES REQUIRED BY YOUR INSURANCE PLAN.
2. It is the responsibility of the patient to provide our office with **accurate** insurance information.
3. While the filing of insurance is a service that we provide to our patients, all charges are your responsibility from the date of service. **IT IS THE RESPONSIBILITY OF THE PATIENT TO MAKE SURE WE ARE A PARTICIPATING PROVIDER/ IN NETWORK PROVIDER OF THEIR INSURANCE PLAN.** ANY PORTION OF THE BILL THAT IS **NOT** PAID BY YOUR INSURANCE, FOR WHATEVER REASON, IS **YOUR** RESPONSIBILITY AND ARRANGEMENTS FOR PROMPT PAYMENT ARE REQUIRED.
4. Returned check fee is \$30.00.
5. If Medicaid and under a Narcotic Agreement, you are required to pay \$10.00 for each urine sample, as insurance does not cover this.
6. Appointments that cannot be kept must be cancelled **24 hours prior** to the appointment.
7. A charge of **\$75.00** will be applied if you **no-show** for your injection or nerve block appointment and a charge of **\$25.00** for a **no-show** for a follow-up appointment. Please inform us 48 hours before so that we can get in another patient. Please keep in mind that we do our best to accommodate patients scheduling. If you should be more than 15 minutes late we may need to reschedule for another time and day.
8. An administrative fee of \$35.00 for any request for medical records. These fees must be paid in full before the records will be copied.

We realize that temporary financial problems may occasionally affect timely payments of your account. If such problems arise, you must contact us.

I, (print name) _____, have read the Financial Policy of Dolora Pain Management Associates, P.C. I understand and agree to all the terms of the policy as stated.

Signature _____

Date _____

Commitment to chronic, and cancer pain management.
website: www.dolorapain.com