Pain Institute
of Southern Arizona

Appointment Scheduling: (520) 999-9000
General Inquires: (520) 318-6035
Fax: (520) 795-9953
www.pisapain.com

Financial Policy and Waiver

Directions: If filling out the form on your computer, save the file and then attach the form to an email and send to patientforms@pisapain.com. If filling out the form on your phone, forward as an email (using the icon) and email to: patientforms@pisapain.com. You can also print the forms to write the answers, then scan or take a photo of the forms and email to patientforms@pisapain.com.

Insurance Benefits
Arizona State Law requires that medical claims be paid by the insurance carrier within 30 days. As a courtesy we will bill your insurance carrier for all covered services. If your insurance has not appropriately paid the submitted claim within 45 days, all outstanding balances will become the patient's responsibility.

Insurance Co-Payments
In accordance with my insurance contract, I understand that co-payments are **due at the time of service**. This contractual obligation requires that the co-payment be made at the time of service, so it may be necessary to reschedule your appointment if your co-payment is not made.

Deductible
If my insurance deductible has not been met, I understand that full payment up to the total deductible amount will be collected at the time of service.

Co-Insurance
I understand that my plan may have co-insurance amounts and that I will be responsible for the co-insurance amount when my insurance has acknowledged my claim. I will be sent a statement for these amounts and understand that I will need to pay in full any co-insurance balances before any other procedures are scheduled.

Private Pay
If I have no insurance coverage, or insurance with which The Pain Institute of Southern Arizona does not participate, full payment is expected at the time of service.

Verification of Benefits and Non-Covered Services
Insurance policies may differ per patient plan. The Pain Institute of Southern Arizona may provide services that my insurance plan excludes. ***It is my responsibility to verify and understand my coverage benefits and exclusions***. All non-covered services are my responsibility and are due at the time of service.

Collections
I understand that once an account is placed into collection status, all future services must be paid in full at the time of service.

No Show/Late Cancellations/Returned Checks
Cancellations made less than 24 hours in advance, or "No Show" appointments, are subject to a $25.00 cancellation fee. These charges are my responsibility and will not be billed to my insurance carrier.

I have read and agree to abide by this Financial Policy and Waiver.

_____ _____
Patient Name Date

Staff Initials:_____