Innovative
PAIN & PROCEDURAL CENTER

PATIENT FINANCIAL POLICY

Health Insurance can be complex. Many patients have financial responsibility even after their insurance has processed their claim(s). We do file insurance claims on your behalf but please understand that payment is your responsibility regardless of insurance coverage. Your insurance is a contract between you and your insurance carrier, not a contract with us

Depending on the services you have, you may receive two separate statements from our office:

1. Innovative Pain Center is the billing for Dr. Retterath's Professional services.

2. Innovative Procedural Center is the billing for facility charges on any procedures performed in our Ambulatory Surgical Center

If your insurance requires a co-pay, we will collect that at the time of your appointment. If you are scheduled for a procedure in our surgical center, we will verify your insurance benefits and collect any required deductible and/or co-insurance **PRIOR** to your procedure being performed. This will just be an estimate and there may be times you will owe additional after your insurance processes. If an overpayment is made by you, we will refund you within 30 days from the time the overpayment is discovered.

We will do our best to work with you on financial matters when necessary.

I have read, understand, and agree with the above.

Patient/Guarantor signature _____ Date/Time _____

Witness to above _____

Consent and Agreement for Pain Management Therapy

Dr. Retterath and/or his staff may prescribe a medication(s) to me that may help reduce or eliminate my pain. These medications can be called opioids, narcotics or pain pills.

These medications can have risks including, but not limited to:

Sleepiness	Constipation	Nausea
Allergic reaction	Addiction to pain medication(s)	Dizziness
Slowing of breathing and reflexes	Hallucinations	

Please read each statement and INITIAL your understanding and compliance:

I agree to tell you about all my health problems and medications I take. _____

I will keep my scheduled appointments. _____ (2 NO SHOW Appointments – Patient/Physician Termination)

I have no history of substance dependence or abuse. _____

I agree and will pay for blood and/or urine tests as requested. _____

Pain medications have a small chance of being addictive. I understand that my chance for addiction is greater if I have a family or personal history of addiction. _____

If I feel drowsy or am not thinking clearly I will avoid dangerous activities. _____

I will only use one pharmacy to purchase my pain medications. _____

That pharmacy is: _____ in _____.

I will not share or sell my pain medications. _____

I understand that if I need medication refills I must call Thursday before 2:00 PM. _____

IF, Dr. Retterath would take over my pain medications, I would agree to get pain medicines from only Dr. Retterath. _____

If I stop my pain medications abruptly I may experience withdrawal / flu like symptoms. _____

If I lose my prescription or pills they will not be replaced. _____

FEMALES: I certify that I am not pregnant. _____

FEMALES: I certify that I will use appropriate measures to prevent pregnancy while receiving treatment with medications. _____

Should I violate any of the above rules, Dr Retterath retains the right to terminate the patient – physician relationship at will. _____

I agree that you may contact my family, pharmacist(s) and other physician(s) if you have concerns about my medication usage. _____

I agree I have received a copy of this consent and agreement. _____

_____ _____

Signature of Patient/Guarantor Date/Time

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT FORM

I, _____ have reviewed a copy of Innovative Procedural Center LLC and Innovative Pain Center LLC Notice of Privacy Practices. This document is to remain in good standing unless revoked or modified.

_____ _____
Signature of Patient/Guardian Date/Time

CONTACT INFORMATION

It is sometimes necessary to contact you about appointments, test results, or general information. It is permissible to call me at home and/or leave a message with anyone answering the home phone or leave a message on voice mail/answering machine.

_____ Yes _____ No _____
Signature of Patient/Guardian

E-MAIL : _____

SHARING INFORMATION

_____ I agree. Innovative Pain and Procedural Center may review with my wife/husband, (insert his or her name here: _____) information regarding appointments, Prescriptions and medications pertinent medical information or any other information as deemed necessary.

_____ I decline. Innovative Pain and Procedural may NOT speak with my wife/husband regarding Any above issues.

In case of emergency please contact:

Name: _____ Relationship: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

Cell Phone: _____

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AUTHORIZATION FOR TREATMENT: Realizing that I require medical care, I do hereby voluntarily consent to such medical care encompassing such diagnostic procedures and medical treatment by my physician, his assistants, or his designees including consulting physicians and employees affiliated with Innovative Pain Center, LLC and Innovative Procedural Center, LLC as is necessary in the judgment of my physician. I consent to testing for HIV (AIDS) and/or Hepatitis should a health care worker have accidental exposure to my blood or any body substance.

RELEASE OF INFORMATION: I hereby authorize Innovative Pain Center, LLC and Innovative Procedural Center, LLC to release diagnostic and procedural information for the completion of insurance claim forms. I hereby authorize the release of information to third party payers and/or their reviewing contractors to comply with preadmission review and continued stay requirements. I authorize the release of clinical information to referring physicians and facilities for the purpose of continued health care. I understand that all releases described above and those included in Innovative Pain Center, LLC and Innovative Procedural Center, LLC Notice of Privacy Practices shall be governed by said Notice of Privacy Practices.

ASSIGNMENT OF BENEFITS: Authorization is hereby granted for the direct payment to Innovative Pain Center, LLC and Innovative Procedural Center, LLC for all benefits payable to me. I understand I am financially responsible for all charges regardless of insurance coverage.

Innovative Pain Center, LLC and Innovative Procedural Center, LLC utilizes an interdisciplinary team approach to treating and managing pain. A comprehensive evaluation is performed at your initial appointment to determine your current needs and to implement an individualized treatment plan. You may be referred for physical therapy services, occupational therapy services or behavioral medicine services or other treatment services deemed necessary by the interdisciplinary treatment team.

_____ _____

Signature of Patient/Guardian Date/Time

_____ _____

Patient Representative Relationship to the Patient

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MEDICARE AUTHORIZATION AND CONSENT

I authorize Innovative Pain Center, LLC and Innovative Procedural Center, LLC to release medical information about me to Social Security Administration and Health Care Financing Administration or its intermediaries or carrier of any information needed for this or a related Medicare claim. I permit a copy of this authorization and consent to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Signature of Patient/Guardian Date/Time

Advance Directive Status, Living Will, and/or Healthcare Power of Attorney

Does the patient have an Advance Directive?

(Circle Yes or No)

Yes No

Patient/Guarantor Signature: _____
Date/Time: _____

WE DO NOT HONOR ADVANCE DIRECTIVES WHEN A COPY IS PROVIDED FOR YOUR RECORD.

Does Innovative Pain Center have a current copy of the Advance Directive?

Yes – Copy in chart
No - Copy of Advance Directive
□ Ask patient/family member to bring in a copy as soon as possible

Staff Signature: _____
Date/Time:_____