

Comprehensive Pain Management Institute

440 N Greenfield Ave, Suite D, Hanford CA 93230
Tel 559-587-2764, Fax 559-746-0369
Gregory J. Bijak MD

Copyright 2006 - Gregory J. Bijak MD

Patient Financial Policy

You agree to settle all outstanding balances at the conclusion of the visit. If your health care expenses are in part paid for under an insurance plan, this office requires that you pay any deductibles or co-pay at the time of service. As a courtesy to you, we will bill your insurance plan for the portion of your bill that is expected to be covered by insurance. If your plan is one with which we do not contract, please pay in full at the time of service. Dr Bijak is a participating provider with Medicare.

A copy of your insurance card and your official identification is required at the time of your first appointment. This information will be kept in your medical file. In the event surgical procedures become necessary, a verification of benefits will be obtained. Please be aware that this does not guarantee that a procedure will be covered by your insurance, but rather that at the time of the verification the insurance is in effect.

This office will bill your plan directly as a service to you, but not in substitute of your responsibility for payment. Charges which have not been satisfied by insurance in a timely fashion, are your responsibility. You will receive a statement of account balance whenever a balance is due. We expect that all outstanding balances will be paid within thirty (30) days of the receipt of the statement. After sixty (60) days from the invoicing date, interest will begin to accrue on the balance of your account at a rate of 2% per month, or the highest rate allowable by law. All returned checks will incur a \$25.00 service charge.

Please remember that medical services are rendered to each patient at the request of the patient, therefore, each patient is responsible to us for the payment of resulting charges. Request for alternative payment methods will be reviewed on an individual basis. We will do our best to work with you as long as satisfactory progress is occurring in resolution of outstanding account balances.

Should any questions arise, please feel free to contact our office during normal business hours, so that we can address them.

Attestation:

I have read the above policy and agree to comply with its provisions. I request that the office bill the insurance plan directly on my behalf for the services provided. I understand and agree that I remain personally responsible for payment of all charges on the account.

Insurance Company: _____ Policy Number: _____
Patient Name (Printed): _____
Signature: _____ Date of Signature: _____

CPMI – Patient Financial Policy (v.1.0)

Date: _____

Patient Name: _____

CPMI_IDnum: _____

BirthDate: _____