Patient Responsibility:

- You are responsible for all charges resulting from treatment provided by Michael C. Francis, MD, APMC d.b.a. Integrative Pain Medicine Center. We bill most insurance carriers; however, primary responsibility for the account is yours. Your co-payment is always due at the time of service. Any remaining balance owed by you is due when you receive your first bill, unless other financial arrangements are made. If you have a delinquent balance, we may ask you to make a payment at the time of your next visit with us. I understand I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days may be subject to a processing fee.

Insurance Billings:

- It is your responsibility (or that of the financially responsible party) to provide current, accurate insurance billing information. If your insurance information changes, please provide the new insurance information prior to receiving additional care. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible to pay the charges.
- I hereby certify that I (or my dependent) have the insurance coverage that I (or my dependent) presented and assign all benefits directly to Michael C. Francis, MD, APMC d.b.a. Integrative Pain Medicine Center, if any, otherwise payable to the services rendered.

Check Returned:

It is our office policy to charge a $ 25.00 fee for checks that are returned.

Cancellation Policy:

If you are unable to make your scheduled appointment, you are asked to please notify our office within 24 hours of your cancellation. If our office is not notified within 24 hours of your cancellation, you may be billed a “no-show” fee.

Authorization to Release Information:

- In obtaining payment for services, I authorize my healthcare provider, Michael C. Francis, MD, APMC d.b.a. Integrative Pain Medicine Center, to release all information necessary from my medical record to any company that may be responsible for payment of all or part of my provider charges, including my insurance companies or their representatives and my employer or union if they are involved in processing the claim. I authorize the use of this signature for all insurance submissions.
- If I have been referred by, or am being referred to, another healthcare provider, I authorize Michael C. Francis, MD, APMC d.b.a. Integrative Pain Medicine Center to receive and release my medical information for continuing care.
- I also assign Michael C. Francis, MD, APMC d.b.a. Integrative Pain Medicine Center all payments to which I am entitled for medical expenses related to the services reported herewith.

HIPAA:

I acknowledge that I have received a copy of Michael C. Francis, MD, APMC d.b.a. Integrative Pain Medicine Center’s Notice of Privacy Practices. Note: There is also a copy posted in our office.

Consent:

I hereby authorize the doctors and staff of Michael C. Francis, MD, APMC d.b.a. Integrative Pain Medicine Center to administer or perform medical treatment including procedures or services as they may deem necessary or reasonable, including laboratory services and diagnostic procedures. Additionally, I authorize Michael C. Francis, MD, APMC d.b.a. Integrative Pain Medicine Center to obtain my medication history.

**I, OR MY APPOINTED AGENT, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS. I HAVE RECEIVED A COPY OF THIS INFORMATION.**

____________________________________ ______________________________________ _________________

Patient Name (Please Print) Patient’s Signature Date

**If Patient is under 18 years of age or is Otherwise Unable to Sign, Complete the Following:**

Patient is __________ year(s) of age or is unable to sign because: ______________________________________________

____________________________________ ______________________________________ _________________

Signature Relationship to Patient Date

1570 Lindberg Drive, Suite 6 ● Slidell, LA 70458 ● (985) 641-1255 ● fax: (985) 641-1059