FINANCIAL RESPONSIBILITIES

1. The Guardian Headache & Pain Management Institute is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area.

2. Payment for services (insurance co□payment, or full payment) is required at the time of your visit. Your insurance REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit. Without it, you may be required to reschedule. If the services you receive are not covered by your plan, payment in full is required Cash, personal checks, credit cards, and debit cards are accepted.

3., All Self-Pay patients and patients who present without proof of insurance are required to pay $160 at the time of visit with check, cash, money order, or credit card at the time of service. All subsequent visits are to be paid at the time of service. The $160 payment does not include any procedures that may take place. Please ask for a copy of our fees if applicable.

4. If you have health insurance, including Medicare and/or Medicaid, we will file for reimbursement for the services we provided. Your insurance policy is a contract between you and your insurance company. You are responsible for knowing and understanding what services are and are not covered under your policy. If your insurance carrier denies any or all of the payment, for any reason, you will be responsible for the denied amount of the visit. You are required to notify staff immediately when insurance coverage changes.

5. ACCIDENT/WORKERS COMP CASES**:** Patient shall be financially responsible for medical Services related to accident/workers comp if you fail to notify the Guardian Headache & Pain Management Institute in advance of an accident/workers comp injury. You will need to supply us with a date of injury, claim number, insurance company address, phone number and contact person's name prior to coming to the office and sign separate Financial Agreement with your workers comp adjuster or a Letter of Protection with your attorney, if applicable. If they do not pay, due to any Circumstances not related to your case and or accident, the patient is responsible for payment.

6. RETURNED CHECK FEES: Any returned check from the bank for non-payment or insufficient funds shall result in the patient's account being assessed a $35.00 fee per check returned

7. Should you fail to comply with the above stated responsibilities, The Guardian Headache & Pain Management Institute reserves the right to reschedule your visit, refer you to another practice, or dismiss you from our practice.

Patient Signature _____ Date of Birth____□____□____

Date Signed____□____□____