CUMBERLAND PAIN ASSOCIATES, PLC

FINANCIAL POLICY

The following is a general description of our financial policy and how it relates to you as our patient. It outlines what we expect from you, and summarizes what you can expect from our billing service. We employ a standard fee schedule that applies to all patients, without bias based on insurance or lack there of. We will do our best to provide you with an accurate estimate of costs associated with your treatment, upon your written request. Please feel free to ask any questions you might have concerning your financial situation with our practice.

INSURANCE

- Your insurance is a contract between you and your insurance company.
- Insurance is your benefit.
- As a courtesy, we will file your insurance.
- Your deductible and co-pay portion is due on the day of service.
- If you do not have your co-payment, we are not required to see you. We may elect to see you, but there will be a $25.00 charge to send a bill for the co-payment.
- If your insurance requires a referral, it is your responsibility to make sure you have a referral. If you do not have a referral, you will NOT be seen.
- If your insurance is not paid within 60 days, your balance becomes your responsibility and payment is expected at that time.
- Any balance remaining after 60 days will be charged interest at 18% APR.
- Failure to make payment in full, or establish a payment plan with our office after 60 days will result in your account being turned over to our collection agency.
- You will be responsible for all collection costs and reasonable legal costs in addition to the amount originally owed.
- We gladly accept cash, money orders, or checks made payable to Cumberland Pain Associates, PLC.
- Returned checks will be charged a $25 fee.

I, the undersigned, understand the financial policies of Cumberland Pain Associates, PLC and agree to abide by the plan I have signed. In addition, I understand and agree to the following:

- To pay the amount charged by Dr. Bartholomew for all professional treatment and services to the undersigned.
- **I understand that I am financially responsible for any and all charges whether or not they are covered by insurance. In the event that I do not pay as outlined above and collection efforts become necessary, I will pay all costs of collection and reasonable legal fees in addition the amount originally owed.**

Signature of Patient	Date	Signature of Witness	Date