Patient Agreement Form

In order to facilitate your treatment here we ask that you read and sign this agreement and authorization. If you have any questions, please do not hesitate to ask for clarification.

- Fees due to New Jersey Pain Care Center, PC for: Patient co-payment(s), deductible(s), and treatments or fees not covered by a pre-approved medical insurance plan are to be paid prior to treatment.
- We will bill your insurance carrier as a convenience to you, however, if your carrier reimburses you, you agree to inform us of the receipt and to pay us within 10 days.
- If your care is not covered by insurance, you agree to be responsible for payment of all fees in full.
- You understand that, as a patient of New Jersey Pain Care Center, PC you must cancel your appointments at least 24 hours prior to the appointment. Failure to cancel the appointment in a timely manner will result in a **$50 late cancellation fee**.
- You understand that, as a patient of New Jersey Pain Care Center, PC will have 10 days to pay your account in full after your insurance claim has been adjudicated. Failure to do so will result in your account balance incurring interest in the amount of 1.5% per month until your account is paid in full.
- Self-pay patients will have 30 days to pay their account in full. Failure to do so will result in their account balance incurring interest in the amount of 1.5% per month until their account is paid in full.
- I have requested medical services from New Jersey Pain Care Center, PC on behalf of myself and/or my dependent(s), and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.
- I understand that should my account be turned over to an outside collection agency, I will be responsible for any and all additional fees, charges or expenses incurred by New Jersey Pain Care Center, PC for collection of my outstanding account. This includes collection agency fees, state sales tax, attorney fees and/or court costs.

I, the undersigned understand and agree to the above.

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Signature of Patient or Authorized Representative Relationship Date

ASSIGNMENT OF BENEFITS

I hereby assign, transfer, and set over to New Jersey Pain Care Center, PC and the Physician responsible for my treatment sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent. I understand that I am financially responsible for the charges not covered by my insurance. A Photostatted copy of this authorization shall be considered as effective and valid as the original. When signed by a Medicare recipient, this is a lifetime care authorization. Either by the above named carrier or myself may revoke this authorization at any time in writing.

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Insurance Company

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Signature of Patient or Authorized Representative Relationship Date