



Patient Name: _____



Consent to Care

I voluntarily consent to examination, diagnosis and/or treatment. I understand that for the purposes of this consent, "medical or diagnostic procedures" include routine diagnostic examinations, x-ray, communicable disease screening, and other medical treatment normally attendant in outpatient care.

Initial _____

Authorization for Payment Assignment of Benefits

I authorize Colorado Pain and Rehabilitation to file claims with my insurance provider. I authorize my insurance benefit plan to pay directly to Colorado Pain and Rehabilitation the medical and/or surgical benefits otherwise payable to me. I understand I am financially responsible for the charges not covered by this assignment.

Initial _____

Release of Information

I authorize Colorado Pain and Rehabilitation to release any medical information necessary to process my medical claims. If my medical service resulted from a work-related injury or illness, I authorize the written and/or verbal release of information concerning the treatment of my work injury to my employer and employer's insurance company.

Initial _____

Notice Regarding Medication Reports/Prescription Drug Monitoring Program (PDMP)

In accordance with the laws in the state of Colorado, our providers will pull a PDMP report for any patient receiving narcotic medication. We also comply with PDMP reporting standards for any medication dispensed from our in-house pharmacy. In order to prepare and maintain a complete and accurate Electronic Health Record, CPR pulls requests medication history files from pharmacies that participate in electronic prescribing.

Appointment Reminder Options

Please indicate your preference for receiving appointment reminders.

Text Message Cell Phone #: _____ Phone Call Phone #: _____

Email Email Address: _____

Please do not send me any appointment reminders

Please note that you will be charged a **\$25 No-Show or Late Cancellation fee** if you do not show up for your appointment or cancel it with less than a 24 hour notice, except for where prohibited by law. If you are late arriving to your appointment your appointment may be shortened to fit within the remaining time of your allotted appointment slot, or it may be cancelled and rescheduled. This is at the discretion of the provider.

By signing below, I certify that I have read these agreements and/or that they have been fully explained to me, that I understand their contents and that I am patient, or a person duly authorized to execute this agreement and accept all the agreement terms. I permit a copy of these authorizations to be used in place of the original.

Patient Name:

_____ Print Name Signature Date

- OR -
Patient
Representative
or Guardian:

_____ Print Name & Relationship to Patient Signature Date

Billing Practices and Payment Policies

The primary goal of Colorado Pain and Rehabilitation is to provide you with excellent medical care at a reasonable cost. Our fees are based on the value of time and skill needed for diagnosing and treating your illness or injury. For your convenience, we accept payment by check, credit card or cash at all locations.

It is **your** RESPONSIBILITY to:

- Know if your CPR physician participates with your specific insurance plan.
- Understand the coverage that your insurance coverage provides and to contact the insurance plan with any questions. Provide complete and correct billing information to CPR for preparation of the bill for medical care provided. This includes updating us on any insurance, phone, or address changes.

If you are being seen for a WORK-RELATED INJURY:

- You will not be responsible for payment at the time of service.

If you are covered by a PRIVATE INSURANCE plan with which your CPR physician participates:

- You are expected to pay the required co-payment at the time of service.
- Very few insurance policies or managed health plans cover all medical services. If you have a deductible or your insurer does not cover certain services, you will be responsible for payment. CPR will send you a statement showing the amount due which is YOUR responsibility. You are expected to **pay the balance in full within 30 days** of the statement date or to contact the billing department using the contact information shown on your statement to arrange a payment structure. Do not contact CPR directly as we cannot initiate these plans.

If you are covered by an insurance plan that your CPR physician DOES NOT participate with, or if you are a SELF-PAY patient:

- CPR requires payment at the time of visit for the visit portion of your bill, unless other written and signed arrangements are made.
- For Physician services: New patient visits or re-evaluations after having not been seen for a period of 6 months or more are \$250, payable at the time of service. Return patient visits are \$100, payable at the time of service.
- For Chiropractic services: New patient visits or re-evaluations after having not been seen for a period of 6 months or more are \$125, including acupuncture, payable at the time of service. Return patient visits are \$55, \$75 with acupuncture, payable at the time of service.
- You will be billed separately for any additional charges incurred during the visit such as procedures, labs, acupuncture, medication dispensing, or other medical services.
- Self-pay patients will receive a cash pay discount of 50% of billed charges for any additional charges incurred during the visit. If you do not pay the full discounted balance within **30 days of the statement**, the discount will be removed and you will be responsible for 100% of the charges.

If your balance remains unpaid at **60 days** from the statement date:

- You will be assessed an overdue balance fee of \$25 every month until your balance is paid.
- If you have contacted the billing department and arranged a payment plan you can continue your care as long as you are current with your payments as well as paying for any new charges at the time of service.
- If you have initiated a payment plan and have not made your payments regularly or have not made any payments, your account will be sent to collections.
- You will not be allowed to schedule any new appointments until you have caught up on your arranged payments. This may mean that you will not be able to obtain prescription refills.
- You may be discharged from the practice and no longer be able to receive medical care from any CPR physician.

By signing below I certify that I have read this agreement and/or that it has been fully explained to me, that I understand its contents and that I am the patient, or a person duly authorized to execute this agreement and accept its terms.

Patient Name:

Print Name

Signature

Date

- OR -
Patient
Representative
or Guardian:

Print Name & Relationship to Patient

Signature

Date