COMPREHENSIVE PAIN CENTER

2700 Hwy 280 S., Suite 212 Mountain Brook, AL 35223
(205) 878-4368

GENERAL USE ABN

(A)Patient Name: _____(B)Phone #: _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If insurance doesn't pay for (D) Specify Anesthesia for Pain Block **below, you may have to pay.**

Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your Insurance may not pay for:

(D) Specify Service that May not be Covered:	(E) Reason Insurance May not Pay:	(F) Estimated Cost:
Anesthesia for Pain Block	Your insurance only pays for medically necessary services.	$ 150.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive service listed above in (D).

(G) OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want to receive the item listed in (D) above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me on an explanation of benefits (EOB) summary. I understand that if my insurance does not pay, I am responsible for payment, but **I can appeal to my insurance company** by following the directions according to my policy. If my insurance company does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want to receive the service listed in (D) above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance company is not billed.**

☐ **OPTION 3.** I do not want to receive the service listed in (D) above. I understand with this choice that I am not responsible for payment and **I cannot appeal to see if my insurance would pay.**

(H) Additional Information:
This notice gives our opinion, not an official decision by your insurance company. If you have other questions on this notice or insurance billing, call the customer service number on your insurance card, or call your employer for specific benefits information.
Signing below means that you have received and understand this notice and that you also received a copy.

(I)Signature: _____ (J)Date: _____

CPC
Comprehensive Pain Center

Patient Information

❑ Mr. ❑ Mrs. ❑ Miss ❑ Dr. ❑ Single ❑ Married ❑ Other ❑ Male ❑ Female

Full Name: _____ Date of Birth: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Contact

❑ Home Phone: _____ ❑ Mobile Phone: _____

❑ Work Phone: _____ ❑ Other Phone: _____

❑ Email: _____

Emergency Contacts

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Responsible Party for Patient ❑ same as patient information

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Relationship: _____

Employer: _____

Insured Party ❑ same as patient information

Full Name: _____ ❑ Mr. ❑ Mrs. ❑ Miss ❑ Dr.

Date of Birth: _____ Social Security Number: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Employer: _____

Insurance Company Information – Primary

Company: _____ Policy Holder Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Ext. _____ Fax Number: _____

Effective Date: _____ Plan Name: _____ Plan Type: _____

Policy Number/I.D.: _____ Group Number or FECA: _____

Insurance Company Information – Secondary

Company: _____ Policy Holder Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Ext. _____ Fax Number: _____

Effective Date: _____ Plan Name: _____ Plan Type: _____

Policy Number/I.D.: _____ Group Number or FECA: _____

Authorizations

Consent for Treatment I consent to necessary treatment, including drugs, medicine, performance of operations, conduct of X-ray and or other studies, including Telehealth/Telemedicine that may be used by the provider(s), nurse(s) and/or staff.

Patient/Guardian (if patient is younger than 14) _____ Date: _____

Authorization for Release of Information

I authorize COMPREHENSIVE PAIN CENTER to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which maybe assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on-the-job injury.

Assignment of Benefits

I hereby authorize payment directly to COMPREHENSIVE PAIN CENTER to benefits otherwise payable to me, including major medical insurance and payment of surgical and medical benefits, but not to exceed the COMPREHENSIVE PAIN CENTER charges for these services. I understand that I am financially responsible to COMPREHENSIVE PAIN CENTER for charges not covered by this assignment.

Financial Consent

In consideration of all services and supplies provided by COMPREHENSIVE PAIN CENTER, I understand and fully agree that I have full responsibility to pay COMPREHENSIVE PAIN CENTER. I understand that COMPREHENSIVE PAIN CENTER will bill my insurance carrier as a courtesy to me. I accept full financial responsibility for the immediate payment of any charges not covered by my insurance contract. I accept the fees charged as a legal and lawful debt and agree to pay said fee, including any and all costs of collections up to 33 1/3%, attorney fees and or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state.

I agree, in order for COMPREHENSIVE PAIN CENTER to service my account or to collect monies I may owe, COMPREHENSIVE PAIN CENTER and or their agents may contact me by telephone at any telephone number associated with my account, including my wireless telephone numbers, which could result in charges to me. COMPREHENSIVE PAIN CENTER may also contact me by sending text messages or emails, using any e-mail address I provide to them. Methods of contacting may include using prerecorded or artificial voice messages and or use of automatic dialing devices, as applicable.

Please mark one of the following options:

❑ **I would like to receive statements online.**

❑ **I would like to receive paper statements.**

Patient/Guardian (if patient is younger than 19) _____ Date: _____

Comprehensive Pain Center

2700 Highway 280 South

Suite 212

Birmingham, Al 35223

205-878-4368

Patient Name: _____

Social Security Number: _____

Any physician, staff, employee or representative of COMPREHENSIVE PAIN CENTER has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

_____	_____	_____
Name	**Relationship**	**Phone Number(s)**
_____	_____	_____
Name	**Relationship**	**Phone Number(s)**
_____	_____	_____
Name	**Relationship**	**Phone Number(s)**
_____	_____	_____
Name	**Relationship**	**Phone Number(s)**

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to COMPREHENSIVE PAIN CENTER or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals, it may be subject to redisclosure by the individual(s).

Patient Signature: _____ Date: _____

❑Copy given to patient (May use carbonless form to eliminate copying at front receptionist)

Acknowledgement of Receipt of the Notice of Privacy Practices (Select and Sign)

❑I acknowledge that I received the Notice of Privacy Practices upon registration as a patient for COMPREHENSIVE PAIN CENTER

❑I acknowledge that I was offered a copy of the Notice of Privacy Practices upon registration as a patient for COMPREHENSIVE PAIN CENTER but declined receipt.

Patient's Name (please print): _____

Patient's Signature: _____ Date: _____

Comprehensive Pain Center
2700 Highway 280 Suite 212
Birmingham, Alabama 35223
Phone: 205-878-4368
Fax: 855-809-8099

AUTHORIZATION TO RELEASE MEDICAL RECORDS
(This authorization complies with HIPAA)

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

I hereby authorize any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, and family member to release all health information about me.

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release all health information about me:

Person/Organization to Release Information		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

The following health information that relates to service beginning from _____ to _____, may be released:

- Entire Medical Record including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers.
- Patient Histories
- Office Notes (except psychotherapy notes)

- Test Results
- Radiology Studies
- Films
- Referrals
- Consults
- Billing Records
- Insurance Records
- Records Sent by Other Health Care Providers

I further understand that my medical record may include one or more of the following:

- Treatment of communicable diseases, including sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis
- HIV-Related Treatment
- Mental Health Information or Psychological Conditions
- Alcohol or Substance Abuse Treatment
- Genetic Testing

The above person/organization, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of:

□ Change of Doctor

□ Individual Request

□ Specialist Referral

□ Workers Compensation

□ Insurance Purposes

□ Continued Treatment

□ Legal Investigation

□ Other: _____

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature of Patient or Persona Representative	Date Signed:	Description of Personal Representative's Authority:

Comprehensive Pain Center

Cancellation and No-Show Policy & Procedures

Effective January 1, 2024

Comprehensive Pain Center's goal is to provide quality treatment and care in a timely manner to all our patients. We schedule our appointments so that each patient receives the right amount of time to be seen by our providers and staff. We have implemented a cancellation and no-show policy which enables us to better utilize available appointments for our patients in need of pain care. The following policy is regarding patients who fail to keep their scheduled appointments. This is effective January 1, 2024.

Please be courteous and call our office promptly if you are unable to attend an appointment. This time will be given to someone who is in urgent need of treatment. Available appointments are in high demand and your early cancellation will give another person the opportunity to have access to timely care.

Clinic Appointments

- Patients that reschedule their clinic visits 36 hours before their appointment will not be penalized.
- If you reschedule or cancel your visit the day before your scheduled appointment you will be rescheduled 1 time without penalty. If this happens again, you will be charged $50 before you are rescheduled.
- If you reschedule or cancel the day of your scheduled appointment, or miss your appointment, you will be charged $75 before you are rescheduled.
- Once a penalty has been processed, your balance must be paid in full prior to being provided treatment.

Procedure Appointments

- Patients that reschedule their procedure 36 hours before their appointment will not be penalized.
- If you reschedule or cancel your procedure the day before your scheduled appointment you will be rescheduled 1 time without penalty. If this happens again, you will be charged $50 before you are rescheduled.
- If you reschedule or cancel the day of your scheduled procedure, or miss your appointment, you will be charged $150 before you are rescheduled.
- Once a penalty has been processed, your balance must be paid in full prior to being provided treatment.

All account balances must be paid in full prior to being rescheduled

In the event of an emergency when prior notice could not be given, you may submit a letter of appeal within 72 hours of the scheduled appointment to our office manager and we will respond within 48 hours.

_____ _____

Patient Signature Date