



INTEGRATIVE PAIN SERVICES, P.A.

MARK S. WHITE, D.O.

4807 SPICEWOOD SPRINGS ROAD

BUILDING 1, SUITE 1235

AUSTIN, TEXAS 78759

(512) 795-9977 FAX: (512) 418-8445

FINANCIAL POLICIES – PLEASE READ CAREFULLY

Your appointment will be made *after* we have received the completed packet *and* any referral or authorization required by your insurance company. Please arrive 15 minutes prior to your appointment time.

CANCELLATION POLICY

If you need to cancel, please do so 24 hours (one business day) in advance of your scheduled appointment time. This office reserves the right to charge a \$50 fee for missing an appointment or canceling with less than one business day’s notice. The purpose of this fee is to encourage our patients to take their appointments as seriously as we do. That time is reserved for you. If your appointment is not kept, other patients who may need same day visits or earlier appointments are obliged to wait longer than necessary.

NON-SUFFICIENT FUNDS FEE

There is a \$25 fee for checks returned to our office for insufficient funds, closed account, etc. The \$25 fee and the amount of the check must be paid with cash, cashier’s check, credit card or money order. If three checks are returned, we will no longer accept checks as a payment method. As of 3-1-07, we will be using Telecheck for electronic check deposits whenever possible to avoid returned checks.

PAYMENT POLICY

All payments are due at the time of service. This includes co-payments, deductibles, and any portion of your bill that is not covered by your health insurance carrier. Past due balances must be paid before additional services are provided unless payment arrangements have been made prior to your visit. If you need to make “payments” for services, our office utilizes Care Credit for this purpose. Please ask for an application. We will assist you in applying.

FINANCIAL RESPONSIBILITY AGREEMENT

I understand that the information given by my insurance company is “not a guarantee of payment”. I understand that my insurance company may deny payment for certain procedures or treatments. These procedures and treatments may not be covered benefits or the insurance company may later decide that they were “not reasonable”, “not medically necessary”, or “experimental and investigational”. If my insurance company denies payment on a procedure or treatment provided by Integrative Pain Services, P.A., I agree to be personally responsible for payment in full of all services rendered.

Patient/Guardian Signature

Date

Printed Name