DR. KIMBERLY SACKHEIM
PAIN TOTAL CARE

FINANCIAL POLICIES & ASSIGNMENT OF BENEFITS

Assignment of Benefits

I authorize and request that payment of benefits by my insurance carrier be made directly to Spine & Pain Total Care, P.C. (Dr. Kimberly Sackheim) for any services rendered. If I receive payment from my insurance plan for services provided by Spine & Pain Total Care, P.C., I agree to promptly sign the payment over to Dr. Sackheim, or pay the amount directly.

I authorize Dr. Sackheim to use and disclose my health information for any reason necessary for treatment, payment, and health care operations. These purposes include but are not limited to any release of information that my insurance company may ask for regarding reimbursement purposes for services received.

PLEASE INITIAL HERE: _____

Out of Network

Dr. Sackheim is an out of network provider with all insurances. She accepts out of network benefits. Our office will do an insurance benefit verification check as a courtesy and inform you of an estimated out of pocket responsibility before your scheduled appointment. You will be responsible for payment on the date of service due to any out of network deductible or out of pocket maximum amount not met. In addition to any payments I have made, I am aware that Dr. Sackheim will be billing my insurance for the remaining balance. I am aware that I **cannot** submit reimbursement claims to my insurance for payments made to Spine & Pain Total Care, P.C. unless I pay for the services rendered in full at the time of my appointment.

PLEASE INITIAL HERE: _____

Insurance Coverage

Please provide us with your current insurance plan information prior to each visit with Dr. Sackheim and notify us of any changes. We will request a copy of your insurance card to scan and keep on file for our records. Please be aware and provide any required referrals in advance of your scheduled appointment. If you do not provide these before care is provided, you will be responsible for the cost of the care.

PLEASE INITIAL HERE: _____

Payments

All payment is due at the time services are provided. Our office accepts payment in the form of cash, check, credit card, Venmo or Zelle. If you will be paying by credit, debit or FSA card, there will be an additional **3%** fee reflected in the final cost. Bounced checks will be subject to an additional **$30** fee.

PLEASE INITIAL HERE: _____

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Medicare Patients

Dr. Sackheim has opted out of Medicare. Patients will be responsible for payment in full at the time of service. Our office will provide you with a detailed receipt and a copy of Dr. Sackheim's Medicare Opt-Out Letter for you to seek possible reimbursement. There is no guarantee that you will be reimbursed.

PLEASE INITIAL HERE: _____

Policy & Fee Changes

These policies and fees are subject to change. We will do our best to keep you informed of any modifications in advance of your next appointment.

PLEASE INITIAL HERE: _____

If you have concerns about your ability to pay, you can contact us for help in managing your account. If you have questions about these policies, please contact our office by calling (646) 808-3220 or e-mail our office at info@drkimberlysackheim.com.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THESE FINANCIAL POLICIES.

_____ _____

PRINT NAME **SIGNATURE**

_____

DATE