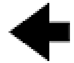
PAIN CONSULTANTS & INTERVENTION- EDWARD POON, MD
3860 MASTHEAD ST NE, ALBUQUERQUE, NM 87109
PHONE: 505.828.1010 FAX: 505.796.9051

1) AUTHORIZATION FOR USE, REQUEST, OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Edward Poon, MD to use, request, re-disclose or disclose any or all of my Protected Health Information to or from any entity involved in the delivery or payment of my medical care.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to above address:

I understand that I have the right to inspect or copy Protected Health Information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)



______________________________________ ______________________
Print **First Name, Middle Initial, Last Name** **Date of Birth**

______________________________________ ______________________
Patient's Signature **Today's Date**

2) FINANCIAL POLICY-YOUR **FULL SOCIAL SECURITY #** IS REQUIRED FOR BILLING:

We accept assignment with many major insurance companies and participating provider plans. However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier.
2. All charges are your responsibility whether your insurance company pays or not.
3. Unpaid deductibles and co-payments are due at the time of treatment.
4. If the insurance company does not pay your balance in full within 60 days we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.
5. Returned checks and appointment no shows without 24 hrs notice will be subject to a $25.00 collection charge. We will notify you by certified letter. If the check is not picked up within 10 days the check will be turned over to law enforcement.
6. Balances over 90 days will be subject to additional collection charges of 7 % per month.
7. Unpaid balances over 120 days are subject to collections via small claims court, attorney, and/or collection agency with applicable collection fees.
8. I give permission to Edward Poon, MD to bill my insurance carrier and to receive payment from my insurance carrier for services rendered.
9. Self Pay: After an initial consultation, the admin staff will discuss with you the costs of the services and payment will be expected. If you are not able to make the payment, please inform the staff **at this time** so that an alternate appointment may be set up for a time that you will be able to pay for services rendered. No injections or further treatment will be made until payment is received in full

I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment.

______________________________ _________________ _______________
Patient's Signature **Full Soc Sec #** **Today's Date**

3) NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received the attached Notice of Privacy Practices.

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Patient's Signature **Today's Date**