



Place Patient Sticker Here

Leaders in Pain Control, Research, and Education

I have received the Notice of Privacy Practices from Millennium Pain Center.

X _____ Date: _____
Signature of Parent / Legal Guardian / Authorized Person

I wish to be contacted in the following manner (check all that apply).

- Home: Phone (____) _____ Work: Phone: (____) _____
o OK to leave message with detailed Information
o Leave message with call back number only
o OK to leave message with detailed information
o Leave message with call back number only
Cell: (____) _____
o OK to leave message with detailed Information
o Leave message with call back number only

Disclosure of Health Information to Designated Personnel

I agree that Millennium Pain Center may disclose my health information to designated personnel to receive my health information regarding my care. Millennium Pain Center will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to such. I have agreed my name may be shared with collaborating physicians and hospital departments.

Table with 2 columns: Print Name of each designated person below, Date of birth. Contains 3 empty rows.

In addition to the above listed persons, I authorize Millennium Pain Center research staff to screen/review my medical chart for eligibility and benefit from new treatments.

Patient Cancellation Policy

Welcome to our practice and thank you for choosing us! We appreciate your confidence and goodwill. Please note our cancellation, no show, and late policy:

- o Patients must give at least 24 hours notice; please call 309-662-4321
o Patients who are 15 (or more) minutes late may have to be rescheduled
o Patients who do not show to appointment or show up late 3 or more times may be discharged.

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Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment on your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

- We accept cash, checks, MasterCard, Visa and Discover
- We offer an extended payment with prior approval
- Your co-payment is due at the time of service
- All immunotherapy vials need to be paid for if they are to be taken out of the office

Regarding Insurance

Whether your insurance pays or not, you are responsible for the appropriate balance. We do require your co-payment or co-insurance (10%, 20%, etc.) to be paid at the time of service. Please be aware of the requirements of your plan. We cannot bill your insurance unless you bring all of your insurance information. Your insurance policy is a contract between you and your insurance company; we may or may not be an "IN NETWORK" provider. It is your responsibility to verify whether we are an "IN NETWORK" provider. Please be aware that some, perhaps all of the services provided may be non-covered services and not considered reasonable and customary under the Medicare Program and /or other medical insurance. Patients who wish to submit claims themselves must pay in full at the time of service, unless other arrangements are made.

Usual and Custom Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our specialty. You are responsible for the appropriate contracted or billed charges regardless of any insurance company's arbitrary determination of usual and customary rates.

Once balance becomes patient responsibility, the account must be paid in full within three (3) months to keep account out of collections. If your account must be turned over to a collection agency, you will be held responsible for collection fees of 35% of the total balance due. In addition, you will be held responsible for any legal and court fees.

Our nurse practitioner/physicians' assistant, may see you independently, but Millennium Pain Center, endorses all of his/her clinical decisions.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to the above policies.

X _____ Date: _____
Signature of Patient or Responsible Party

Printed Name of Patient or Responsible Party