

The Washington Center for Pain Management

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OUR FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept cash, check, Visa and MasterCard.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor – in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit.
4. Not all insurances plans cover all services. In the event your insurance plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

I have read and understand the practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of patient or responsible party, if minor

Date

RELEASE OF MEDICAL INFORMATION

Consent to Disclosure of Protected Health Information: Your protected health information pertaining to your diagnosis and/or treatment at The Washington Center for Pain Management, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus (“HIV”) and Acquired Immune Deficiency Syndrome (“AIDS”), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to The Washington Center for Pain Management to obtain and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our Notice of Privacy Practices provides information about how The Washington Center for Pain Management and its workforce may obtain and/or release protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

Consent to Treatment: I voluntarily consent to receive medical and health care services provided by The Washington Center for Pain Management physicians, employees and such associates, assistants, and other health care providers, as my physicians deem necessary. I understand that such service may include diagnostic procedures, examinations, and treatment. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I understand that this consent to treatment will be valid and remain in effect as long as I attend The Washington Center for Pain Management unless revoked by me in writing such written notice provided to the clinic attended by me.

Release from Liability: I release and agree to hold harmless to The Washington Center for Pain Management and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand The Washington Center for Pain Management cannot be responsible for the use or re-disclosure of information by third parties.

Signature of patient or responsible party, if minor

Date

MISSED APPOINTMENT POLICY

Please be aware that be making an appointment with our physicians that you are agreeing to abide by the billing policies of our service. There will be a **\$35.00** fee, billed to you personally, if you do not provide 24 hours notification of cancellation. You must show up fifteen minutes early for follow-ups and thirty minutes early for new patients and procedure to complete paperwork. By not arriving at the scheduled time for your appointment it may be canceled and rescheduled with a \$35.00 fee. Your insurance company does not cover fees of missed appointments. They must be paid on or before your next scheduled appointment.

Signature of patient or responsible party, if minor

Date