Jeoffrey P. Benson, M.D., Inc.
504 W. Pueblo St., Suite 301 Santa
Barbara, CA 93105
Phone (805) 682-5520 FAX (805) 682-1632

INSURANCE AND BILLING INFORMATION

1. ***Insurance:***

   Knowing your insurance benefits is your responsibility. This is a contract between you and your insurance company. *Please bring your insurance cards to all appointments.* If you change your insurance carrier, please notify our office staff before your visit. If your illness or injury is associated with a workman's compensation claim or automobile accident claim you must inform our office staff before your appointment. If you have not paid your insurance premium or your insurance coverage has terminated, you must notify our office staff. Providing incorrect insurance information can be considered fraud. ***You will be responsible for any charges that are not paid due to providing incorrect insurance information.***

2. ***Co-payments and Deductibles****:*

   All co-payments and deductibles are due at the time of service. This arrangement is part of your healthcare coverage with your insurance company. Failure on our part to collect co-payments and deductibles from patients is a violation of our contract with the insurance company.

3. ***Pre-authorization:***

   Many procedures require pre-authorization for payment. Our office will try to obtain authorization prior to performing a procedure. For some procedures, insurance companies do not require pre-authorization but will only pay for the procedure if they consider it *"medically necessary"*. This means that the insurance company will determine whether payment will be made *after the procedure has been performed.* ***If you have a procedure which is determined to be "not medically necessary", then you will be responsible for payment.***

4. ***Claims Submission:***

   We will submit your insurance claim and assist you in any reasonable way to help process your claims. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests for information. We will make a reasonable effort to process your claim***. If your claim is still under dispute or not paid within 90 days, you will be responsible for payment. If your insurance company determines that a claim was paid in error or demands a refund within two years, you will be responsible for payment.***

5. ***Missed appointments:***

   "No shows" and cancellations without adequate notice affect other patients who could have been seen earlier***. If you miss an appointment without adequate***

notice, our office may charge you a $80.00 fee. This will not be covered by insurance.

6. ***Medicare patients:***

   Our office is a "participating provider" with Medicare. This means that we will bill Medicare directly for professional services and accept the amount designated by Medicare for that service. Medicare will pay 80% of this amount. You or your secondary or co-insurance are responsible for the remaining 20%. ***Medicare and secondary insurers may also require co-payments and deductibles. You are responsible for paying these charges.***

7. ***Other insurance billing policies:***

   Your insurance company may also require co-payments or have a deductible amount which you must pay before the insurance will pay. It is your responsibility to understand these and the amounts that may apply to you.

8. ***Returned check charge:***

   A charge of $25.00 will be made for any non-paid check.

9. ***Non-payment of overdue account:***

   Overdue accounts will be forwarded to a collection agency. After this has been done, our office can no longer accept direct payments on your account.

CONSENT TO INSURANCE AND BILLING PRACTICES

I have read the insurance and billing practices, understand and agree to the abide with them.

_____ _____

Signature Date

_____

Print Name

The health insurance company responsible for your evaluation and treatment is

(1)_____

(2)_____

By signing this form, you are verifying that the above information regarding your insurance is correct. If your illness, injury or pain problem is the result of an auto accident or workman's compensation claim, your personal health insurance company may not pay for your evaluation and treatment. If this is the case, you must provide us with the name of the responsible insurance company.

Note: It is illegal to give false health insurance information. Providing incorrect health insurance information may result in delay of treatment, additional cost to you and possible legal action by your insurance company.

_____
Signature

_____
Print Name

_____
Date

NOTICE OF PATIENT PRIVACY
Acknowledgement of Receipt
Date_____

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We may require your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed *Notice of Privacy Practices* which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact Carol Cope, Director of Nursing, at our office at 805-898.1111.

I acknowledge receipt of the *Notice of Privacy Practices* of Pain Management Institute.

Signature_____
Date_____

Jeoffrey P. Benson, M.D., Inc

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name_____Date of Birth_____
Address_____
Social Security#_____Telephone#_____

Type of information to be released:
__Operative and Procedure Report(s)
__Complete health record
__Complete insurance & billing records
__Pertinent documentation
__Other (please specify)_____

Period of Records:
From (date)_____To (date)_____
From (date)_____To (date)_____

Purpose of Request:
__Treatment or Consultation
__Billing or Claims Payment
__At the request of the patient
__Other (please specify): _____

Release information to:
Name_____
Address_____
_____
Phone _____ Fax#_____

Drug and/or Alcohol Abuse, Psychiatric, Psychological Care, and/HIV/AIDS Records
I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, Sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS testing and/or treatment, and/or sensitive information. I agree to its release.

Time Limit & Right to Revoke Authorization
Except to the extent that action has already been taken on this authorization, I understand that I can at any time revoke this authorization by submitting a notice in writing to Dr. Benson at 504 W Pueblo St #301 Santa Barbara, CA 93105. Unless revoked, this authorization will expire on _____ (date) or _____ (event), or one year from date of signature, unless otherwise specified.

I, the undersigned, authorize and request Dr. Benson to release information to the party designated above.

Signature_____ Date___/___/____