American Pain Institute, LLC
14 Manchester Sq, Suite 290
Portsmouth, NH 03801

Financial Policy, Consent to Bill

Medical Insurances, Managed Care Insurances:
We participate with and bill most of the major insurances. Please check with us AND your company to verify coverage.

If your insurance requires a referral, YOU are required to obtain the referral.
If your insurance requires the referral, and none is in place, YOU are responsible for payment.

Payment at time of service
Co-pays are due at time of service, no exceptions
If you are paying for services yourself, they are payments due at time of service, no exceptions.

Payment Options
We accept cash, money orders,credit cards (Mastercard, Visa, Discover, American Express).
We regret that we are unable to accept checks.

Missed Appointments or Cancellations with less than 24 hour notice
You may be subject to a $50.00 cancellation fee. YOU are responsible for the fee, not your insurance carrier.

I HAVE READ THIS FINANCIAL POLICY AND VERIFY THAT ALL INSURANCE INFORMATION IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AS OF THIS DATE.

I AUTHORIZE ASSIGNMENT OF INSURANCE BENEFITS TO AMERICAN PAIN INSTITUTE, LLC FOR THE PURPOSE OF PAYMENT TOWARDS SERVICE RENDERED BY JOSHUA GREENSPAN, MD OR AMERICAN PAIN INSTITUTE, LLC.

I **UNDERSTAND AND AGREE** THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR MY ACCOUNT AND ANY PROFESSIONAL SERVICES RENDERED.

PRINTED NAME ____DATE OF BIRTH___________

SIGNATURE____DATE______________________