PRACTICE POLICIES

APPOINTMENT CANCELLATION POLICY: I fully understand and agree to be bound by the policy that if I must cancel or reschedule my scheduled appointment, I must notify Virginia Interventional Spine Associates >24 hours in advance of the time of the scheduled appointment. Accordingly, because of the nature of the medical profession, I fully understand and accept full financial responsibility for the customary financial charge of $50.00 for the allocated time of all missed appointments. I understand that no further appointments will be made for me until the $50.00 charge is paid.

COPAYMENT/DEDUCTIBLE POLICY: I fully understand and agree to be bound by the policy that all applicable financial co-payments and deductibles are due at the time of service by Virginia Interventional Spine Associates, as my healthcare insurance plan may not cover all the financial expense of the services provided to me by Virginia Interventional Spine Associates.

RETURNED CHECK POLICY: I fully understand and agree to be bound by the policy that I will be responsible for a $75.00 returned check fee plus any additional fees charged to Virginia Interventional Spine Associates by their financial institution should I provide them with a check that is returned for any reason, most commonly insufficient funds.

FOLLOW-UP POLICY: I fully understand and agree to be bound by the policy that I am to maintain regularly scheduled follow-up clinic visits as defined by my prescribed treatment plan by Virginia Interventional Spine Associates, at which times I will bring the original containers of my pain management medications.

PRESCRIPTION REFILL POLICY: I fully understand and agree to be bound by the policy that prescription refills will be performed at the time of my routine follow-up care during the operational clinic hours of Virginia Interventional Spine Associates. I fully acknowledge that Virginia Interventional Spine Associates will not provide an early refill of a controlled-substance therapy prior to the scheduled refill date as defined by my prescribed treatment plan.

EMERGENCY CARE POLICY: I fully understand and agree to be bound by the policy that in the event of a medical emergency, I will either call 911 or report directly to the emergency medicine department of the nearest hospital for evaluation and treatment. In the event of a medical non-emergency, during the office hours of Virginia Interventional Spine Associates, I will call the office at 540.374.3233 for instructions regarding evaluation and treatment.

TELEPHONE CONSULT POLICY: I fully understand and agree to be bound by the policy that the clinical staff members at Virginia Interventional Spine Associates will answer the majority of my telephonic inquiries regarding my pain management care. I fully understand that should my question require the attention of the physician or PA, my inquiry will be reviewed with him/her by a clinical staff member and a call will be made to me by the clinical staff member. I understand it is unlikely that telephone calls can be taken immediately by clinical staff members. A message can be left on the nurse voicemail line and a clinical member will contact me back as soon as possible however, you most commonly will receive a return call within 48 hours.

BLOOD DRAW POLICY: I fully understand and agree to be bound by the policy that I consent to the confidential, free testing of a blood sample from my body to be tested for HIV (AIDS) and other communicable diseases, should a staff member of Virginia Interventional Spine Associates have an accidental exposure to my blood or body fluid.

CHILDREN POLICY: I fully understand and agree to be bound by the policy that no children under the age of 12 are allowed in the examination rooms of Virginia Interventional Spine Associates. I fully acknowledge that should I bring children to Virginia Interventional Spine Associates, I must provide a responsible adult to supervise my children in the waiting room.

MEDICAL RECORD COPY POLICY: I fully understand and agree to be bound by the policy that for a request to copy my medical records there will be a minimum financial charge of $15.00 for the first 15 pages followed by a financial charge of $0.25/page directly to me. I fully acknowledge that financial payment with a signed HIPAA compliance release form must be provided directly by me to Virginia Interventional Spine Associates prior to the release of copies of my medical records. Payment must be made in cash or by check.

FORM COMPLETION POLICY: I fully understand and agree to be bound by the policy that for a request to complete a form that Virginia Interventional Spine Associates agrees to complete, there will be a *minimum* charge of $15.00. I fully acknowledge that financial payment must be provided directly by me to Virginia Interventional Spine Associates prior to the release of the form. Payment must be made in cash or by check.

FINANCIAL CONTRACT POLICY: I fully understand and agree to be bound by the policy that financial payment is due at the time of service by Virginia Interventional Spine Associates. I fully acknowledge that I have been given ample opportunity to discuss this policy in full with all of my questions answered to my complete satisfaction by the staff of Virginia Interventional Spine Associates such that I fully accept full financial responsibility for all charges for services provided to me by Virginia Interventional Spine Associates not covered by my healthcare insurance. I fully assign directly to Virginia Interventional Spine Associates all benefits, otherwise payable to me for services provided to me by Virginia Interventional Spine Associates. I fully authorize Virginia Interventional Spine Associates to release all information necessary to secure the payment of benefits to Virginia Interventional Spine Associates. I fully authorize the use of my signature below on all manual or electronic insurance submissions. Certain test(s) may be ordered by Virginia Interventional Spine Associates; in which, I fully agree to be financially responsible for these services should they be considered "non-covered" or "not medically-indicated" by my healthcare insurance. If my treatment is involved with a work-related injury and Virginia Interventional Spine Associates is to file Workmans' Compensation claims on my behalf, I fully authorize Virginia Interventional Spine Associates to discuss the plan of treatment, care and appointment information with the claims payers or caseworkers.

DELINQUENT ACCOUNT POLICY: I fully understand and agree to be bound by the policy that financial payment is due at the time of service by Virginia Interventional Spine Associates. Should my account become delinquent >30 days, I fully authorize an additional 1.5% finance charge be added monthly to my account until collection by Virginia Interventional Spine Associates. In the event that my delinquent account is forwarded to an attorney/agent for collection by Virginia Interventional Spine Associates, I fully authorize an additional payment by me equaling 30% of the highest outstanding balance as reasonable fees for an attorney/agent to collect my delinquent account for the services provided to me by Virginia Interventional Spine Associates.

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PATIENT DECLARATION: I have thoroughly read each policy of Virginia Interventional Spine Associates. I fully acknowledge that I have been given ample opportunity to discuss each policy with all of my questions answered to my complete satisfaction by the staff of Virginia Interventional Spine Associates. I fully understand and agree with each policy of Virginia Interventional Spine Associates. I fully affirm that I have complete capacity and legal authority to agree and be bound by each policy. I fully understand and agree to accept each policy of Virginia Interventional Spine Associates. I confirm that I have received a copy of this form of the Policies of Virginia Interventional Spine Associates.

______________________________	______________________________	______.______.______
Patient or Representative Signature	Witness Signature	Date
______________________________	______________________________	
Print Name	Relationship to Patient	