SC PAIN & SPINE SPECIALISTS LLC

NEW PATIENT PAIN EVALUATION FORM

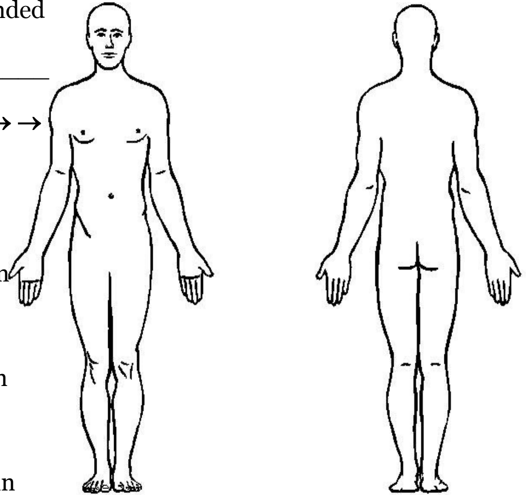
Patient Name: ____ DOB: ____________ Age: _____

Place of Birth: City ______________ State___ Country ______ Who referred you to our office? _____________

Who is your primary care doctor? Name: ________________________ Practice Name: ____________________

Height: _______ Weight: _______ Please circle: Male Female R-Handed L-Handed

Where is your pain? ____



Please indicate your area of pain on the body diagram to the right. →→→→→→

Please rate the intensity of your pain below:

What is the pain at its ***WORST****?*

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

What is the pain at its ***BEST****?*

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

What is your ***CURRENT*** *pain level?*

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

When did your pain start? ____

Was there an injury or precipitating event? Yes / No If yes, please indicate date of injury and describe what happened: ___________

____

Have you had any of the following studies? MRI CT scan X-ray Myelogram Date Performed: ___________

Type of Exam (cervical, lumbar, brain, etc.): _________________________ Facility: ____________________

Have you had back surgery? Y / N Type/Date/Facility: ____

Please indicate which of the following therapies you have tried FOR THIS PROBLEM and whether they have helped.

NSAIDs	Did it help? Yes / No / Not Tried	Brace/Collar	Did it help? Yes / No / Not Tried
Physical Therapy	Did it help? Yes / No / Not Tried	Epidural steroid injections	Did it help? Yes / No / Not Tried
Oral steroids	Did it help? Yes / No / Not Tried	Chiropractic therapy/OMT	Did it help? Yes / No / Not Tried
Pain medication	Did it help? Yes / No / Not Tried	Tens Unit	Did it help? Yes / No / Not Tried
Muscle relaxants	Did it help? Yes / No / Not Tried	Other:_______________	Did it help? Yes / No / Not Tried

FOR CLINICAL STAFF ONLY: BP ___________ P __________ R ___________ O2 Sat. ___________

CLINICAL SUMMARY:

Intake Clinician Signature: ______________________

Patient Name: ____ **Date of Birth:** ____________________

Have you seen other doctors for this problem? Yes / No Name(s): ____

Do you have any areas of numbness? Yes / No If yes, where? __________________ When did it begin? ______________

Do you have any areas of weakness? Yes / No If yes, where? __________________ When did it begin? ______________

Describe the **TYPE** of pain you are having (circle all that apply):

aching *burning* *shooting* *sharp* *stabbing* *dull* *cramping* *throbbing* *gnawing*

sickening *fearful* *punishing* *cruel* *tearing* *tender* *other:* __________________

Where is the pain most present? ____

Does the pain radiate from the main area of pain? Yes / No If yes, to where? ____________________________________

What makes your pain worse? ____

What makes your pain better? ____

What daily activities are currently affected by your pain/discomfort (e.g., washing dishes, getting the mail, cooking)? ______________

____

What is the **ONE** most important activity you wish you could do today, but can't do because of your pain? ____________________

____

What are you currently taking for pain control? ______________________________ Dosage/Frequency: ______________

Prescribing Physician: ____ Phone No. ____________________

Did you complete a Universal Medication Form? Yes / No **ALLERGIC TO IODINE OR SHELLFISH?** Yes / No

OTHER ALLERGIES? Please indicate type: ____

Do you currently take **ASPIRIN**? Yes / No Other **BLOOD THINNERS**? Yes / No If yes, please list: __________________

____

FAMILY PAST MEDICAL HISTORY:

Mother: ____ Living? Yes / No Current age or age at death: _____

Father: ____ Living? Yes / No Current age or age at death: _____

Other history of family illness? Yes / No If yes, please list: ____

SOCIAL HISTORY:

Single Married Divorced Widowed Children: Yes / No How many? __________________

Are you currently **working**? Yes / No Full-time / Part-time / Retired Occupation: ____________________________

Do you ***currently*** **smoke**? Yes / No How much per day? ______________ For how many years? ____________________

Did you ***previously*** **smoke**? Yes / No How much and for how many years? ___________ Quit date: ____________________

Do you **drink alcohol**? Yes / No How much? ___________________ How often? ______________________

Do you **use illicit drugs**? Yes / No Current or Prior? ________________ Name of Drug(s): ______________________

Did you serve in the **Military**? Yes / No Current or Prior? ________________ Branch: ____________________________

Highest Level of **Education** (please circle): Grammar School / High School / College Degree: ______________________

REVIEW OF SYSTEMS

Today's Date: ___________

Patient Name: ____ Date of Birth: ___________

Are you **CURRENTLY** experiencing any of the following symptoms? Please check all that apply **TODAY**:

CONSTITUTIONAL
- Fever
- Chills
- Fatigue
- Weakness
- Weight Loss
- Weight Gain
- Night Sweats
- Difficulty Sleeping
- Decline in Health

OPHTHALMOLOGY (EYES)
- Blurry Vision
- Double Vision
- Eye Pain
- Vision Loss
- Sensitivity to Light
- Dry Eyes

CARDIOVASCULAR
- Chest Pain
- Palpitations
- Short of Breath on Exertion
- Swelling of Legs
- Varicose Veins
- Leg Pain with Walking
- Fainting
- Recent EKG

MUSCULOSKELETAL
- Neck Pain
- Back Pain
- Muscle Stiffness
- Muscle Cramps
- Blood in Urine
- Joint Pain
- Memory Loss
- Joint Swelling
- Joint Stiffness
- Instability/Falls
- Joint Swelling

GASTROINTESTINAL
- Indigestion
- Heartburn
- Dry Mouth
- Nausea
- Vomiting
- Regurgitation
- Abdominal Pain
- Loss of Appetite
- Bloody Stools
- Diarrhea
- Constipation
- Jaundice
- Rectal Bleeding

OTOLARYNGOLOGY (EAR/NOSE/THROAT)
- Trouble Hearing
- Ringing in the Ears
- Vertigo (Spinning)
- Ear Pain
- Ear Discharge
- Hoarse Voice
- Trouble Swallowing

ENDOCRINE
- Heat Intolerance
- Cold Intolerance
- Weight Loss
- Weight Gain
- Excessive Appetite
- Increased Thirst
- Excessive Urination
- Change in Sweating

SKIN/INTEGUMENTARY
- Hair Loss
- Nail Changes
- Dryness
- Itching
- Suspicious Moles
- Skin Rash

NEUROLOGICAL
- Headaches
- Weakness
- Numbness
- Tingling
- Fainting
- Clumsiness
- Blackouts
- Tremors
- Seizures
- Paralysis
- Memory Loss
- Slurred Speech
- Dizziness

RESPIRATORY
- Chronic Cough
- Coughing Blood
- Short of Breath
- Wheezing
- Recent Chest X-Ray

HEME/LYMPHATIC
- Abnormal Bleeding
- Abnormal Bruising
- Nose Bleeds
- Swollen Glands

GENITOURINARY
- Incontinence - Bowel
- Incontinence – Bladder
- Frequency/Urgency
- Painful Urination

PSYCHIATRIC
- Feeling Depressed
- Disorientation
- Suicidal Thoughts
- Hallucinations

Revised 02/08/2022

SC PAIN & SPINE SPECIALISTS LLC

PAST MEDICAL/SURGICAL HISTORY

Today's Date: ______________

Patient Name: ____ Date of Birth: ______________

Have you **EVER** had or been diagnosed with any of the following? Please check **ALL** that apply:

NEUROLOGICAL (BRAIN & SPINE)

- Stroke (CVA)
- Mini-Stroke (TIA)
- Seizures
- Fainting
- Tumor
- Paralysis
- Headaches
- Parkinson's Disease
- Migraines
- Restless Leg Syndrome (RLS)
- Family History of Neurological Disease

RESPIRATORY

- Asthma
- Bronchitis
- COPD
- Emphysema
- Pneumonia
- Shortness of Breath
- Sleep Apnea
- Use CPAP Machine
- Use Oxygen
- Pulmonary Embolism (PE)
- Tuberculosis
- Chronic Cough

GASTROINTESTINAL

- Acid Reflux (GERD)
- Peptic Ulcers (Stomach)
- Abdominal Pain
- Nausea
- Diverticulosis
- Hemorrhoids
- Ulcerative Colitis
- Irritable Bowel Syndrome
- Vomiting
- Loss Of Appetite
- Rectal Bleeding

DERMATOLOGY

- Rashes
- Psoriasis
- Fungal Infections
- Delayed Healing of Wounds
- Skin Cancer

MUSCULOSKELETAL

- Osteoarthritis
- Rheumatoid Arthritis
- Gout
- Fibromyalgia
- Lupus
- Connective Tissue Disease
- Knee Replacement - Please Circle: Right Left
  Date: ____________
- Hip Replacement - Please Circle: Right Left
  Date: ____________

PSYCHIATRIC

- Bipolar
- Schizophrenia
- Anxiety
- Depression
- Suicidal Thoughts

CARDIOVASCULAR

- High Blood Pressure
- Chest Pain
- High Cholesterol
- Heart Murmur
- Atrial Fibrillation
- Heart Attack
- Congestive Heart Failure
- Varicose Veins
- Mitral Valve Prolapse
- DVT - Blood Clot
- Pacemaker/Defibrillator
- Peripheral Vascular Disease/Poor Circulation
- Open Heart Surgery - Date: ______________________
- Cardiac Stents - Date: _________________________
- EKG - Date: _______________________________

ENDOCRINE

- Thyroid
- Diabetes

GENITOURINARY

- Bladder Infections
- Kidney Stones
- Enlarged Prostate (BPH)
- Kidney Infections
- Kidney Failure/Dialysis
- Kidney Dysfunction

OPHTHALMOLOGY (EYES)

- Wear Glasses/Contacts
- Glaucoma
- Macular Degeneration
- Cataract: Please Circle: Right Left
- Blindness: Please Circle: Right Left

OTOLARYNGOLOGY (EAR/NOSE/THROAT)

- Ear Infections
- Sinus Problems
- Vertigo (Spinning)
- Hearing Loss

HEMATOLOGIC/IMMUNE SYSTEM

- Low Platelet Count
- Anemia
- Bleed/Bruise Easily
- Bleeding Disorder
- Lymphoma
- Leukemia
- Hepititis B
- Hepatitis C
- HIV/AIDS

GYNECOLOGICAL

- Currently Pregnant
- Menopause
- Hysterectomy
- Previous Pregnancies: # ______
- Previous Deliveries: #________

CANCER:

Type: ______________________________________ Chemotherapy Radiation

Other Treatment: ____

PRIOR SURGERIES, **IMPLANTS** or **HOSPITALIZATIONS** not indicated above (include dates): ______________

____

____

Revised 01/20/2022

UNIVERSAL MEDICATION FORM

Patient Name / DOB: ____

Today's Date: __________________________

PHARMACY NAME	PHONE NUMBER	LOCATION	
COVID VACCINES	**VACCINES: Date of Last Dose**	**HEIGHT**	**WEIGHT**
1st Dose:	Flu:		
2nd Dose:	Pneumonia:		
Booster:	Shingles:		
ALLERGIES / DESCRIBE REACTION:			

I grant permission for SC Pain & Spine Specialists, LLC to review my pharmacy record online:* **YES / NO ______(initial)

Please list all current medications: Include **prescription** and over-the-counter medications such as **aspirin,** anti-inflammatories or antacids, as well as herbal supplements and vitamins, ginseng, garlic, fish oil, etc.
Also include medications taken **as needed** like nitroglycerin.

PATIENT TO COMPLETE			STAFF to complete at each Date of Service													
Current Medications	**Dose**	**How often do you take the medication?**														

Please list the provider that prescribes any anticoagulant, antiplatelet, or "blood thinner" medication(s) for this patient:

____

Staff Initials	Staff Signature	Staff Initials	Staff Signature
________	______________________________	________	______________________________
________	______________________________	________	______________________________
________	______________________________	________	______________________________

UNIVERSAL MEDICATION FORM

Patient Name / DOB: ____

Today's Date: _________________________

PATIENT TO COMPLETE			STAFF to complete at each Date of Service													
Current Medications	**Dose**	**How often do you take the medication?**														

Please list the provider that prescribes the anticoagulant, antiplatelet, or "blood thinner" medication(s) for this patient:

____

Staff Initials	Staff Signature	Staff Initials	Staff Signature
________	______________________________	________	______________________________
________	______________________________	________	______________________________
________	______________________________	________	______________________________

PATIENT REGISTRATION FORM

Patient First Name:_________________________ Middle Initial: ______ Last Name: ____________________________

Street Address: ____

City: ______________________________ State: _____________ Zip Code: _______________________

Primary Phone Number: ___________________________ Secondary Phone Number: _________________________

Social Security No.: _______________________ Date of Birth: ___________________ Sex: Male / Female

Marital Status: Single Married Separated Divorced Widowed

Employment Status: Full time Part time Retired Unemployed Student

Employer/School: ____ Phone: _____________________

Emergency Contact/Release Medical Information: ____

Relationship: ____ Phone: __________________________________

Referring Physician: _______________________________________ Phone: __________________________________

I authorize SC Pain & Spine Specialists to leave messages including Personal Health Information on my voicemail.

I authorize SC Pain & Spine Specialists to contact me via email and text message with appointment reminders, review requests, & general healthcare information. You may receive messages from us, our affiliates, & 3rd-party vendors that perform services on our behalf. Messages sent to you via email & text are not confidential methods of communications & may not be secure. Your consent is not a condition of services. Message & Data rates may apply.

Email address: _______________________________________ Cell number for text message:______________________

INSURANCE INFORMATION

Primary Insurance:____ Effective Date: ____________________

Address: ____ Phone: __________________________

Guarantor: ____ Relationship:______________________

Group No.: _________________________ ID No.: _______________________ Subscriber Date of Birth: _____________

Secondary Insurance:____ Effective Date: ____________________

Address: ____ Phone: __________________________

Guarantor: ____ Relationship:______________________

Group No.: _________________________ ID No.: _______________________ Subscriber Date of Birth: _____________

Authorization for release of information and to pay insurance benefits: SC Pain & Spine Specialists, LLC is hereby authorized to release information to healthcare providers that have referred me to this physician or who may benefit from this information as they care for me in the future. I authorize release of medical information to my insurance carrier, their utilization management agency, my employer, or any other agency that may be assisting in payment for my care. In the event of hospitalization, I hereby assign payment to SC Pain & Spine Specialists, LLC for surgical and/or medical benefits otherwise payable to me.

____ ________________________

Patient Signature *(if parent of guardian, please indicate relationship to patient)* Date

____ ________________________

SCP&SS Representative Date

FINANCIAL POLICY

Patient Name: ___________________________________ **Date of Birth:** _____________

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance about our office policies and what to expect at your visit allows for a good flow of communication and enables us to achieve this goal. Please read this carefully and do not hesitate to contact a member of our staff with any questions.

1. On arrival, please sign in at the front desk and present your current identification and insurance card(s) at every visit. We will check these against our current records for accuracy and update as needed to ensure that all claims are filed on your behalf with the most current information you have provided us. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL RECEIVE AN INVOICE AND WILL BE RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED. YOU WILL HAVE 30 DAYS FROM THE DATE OF SERVICE TO SUBMIT CORRECT INSURANCE INFORMATION FOR US TO REBILL ON YOUR BEHALF.

2. According to your insurance plan, you are responsible for any and all deductibles, copays, and coinsurance. SC Pain & Spine Specialists will initiate prior authorizations for all procedures ordered.

   I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR THE COST OF THE PROCEDURE IF THE PROCEDURE IS CONSIDERED EXPERIMENTAL OR INVESTIGATIONAL BY MY INSURANCE CARRIER, AND/OR IS NOT COVERED UNDER MY MEDICAL POLICY FOR ANY OTHER REASON.

   Initial: ___________

3. It is your responsibility to understand your benefit plan and to know if a written referral or authorization is required to see a specialist, if preauthorization is required prior to a procedure, and what services are covered.

4. If our Providers do not participate in your insurance plan, payment in full will be required when service is rendered. Prior balances must be paid before your visit or procedure or we reserve the right to reschedule you until such time you can pay the balance due.

5. If you have no insurance, we require full payment in advance of our New Patient fee, and fees for all subsequent visits will be required to be paid upon check-in. If you are unable to pay in full at the time of your visit, we reserve the right to reschedule you until such time as you can pay the balance due.

6. All copayments are due at time of service. No exceptions will be considered as this is a Provider contractual obligation with insurance company, and we are bound to insurance contractual obligations.

7. Patient balances are billed immediately on receipt of your insurance plan's Explanation of Benefits (EOB) and are due within 10 days of receipt of your bill.

Patient Name: ______________________________ **Date of Birth:** ____________

8. If previous arrangements have not been made with our office, any account balance outstanding for greater than 30 days will be considered past due and will be subject to collection activity. Any outstanding balance that is greater than 90 days will be forwarded to collection agency for further collection activity. **IF YOUR ACCOUNT IS SENT TO THE COLLECTION AGENCY, YOU WILL BE RESPONSIBLE FOR THE BALANCE FOR SERVICES RENDERED AND THE COLLECTION AGENCY FEES.**

9. Our office offers a one-time installment plan for the New Patient fee and/or procedure fees in excess of $200.00. You must sign an Installment Agreement authorizing us to use a debit or credit card to process your balance in three monthly installments not to exceed 60 days from original appointment/date of service. No more than one Installment Agreement will be authorized to be in effect per patient. If an authorized draft is declined for any reason, the patient is considered to be in breach of the Installment Agreement, and the balance will be due immediately from patient. No further appointments will be honored until past due balances are paid in full.

10. **CANCELLATION POLICY:** We require a 24-hour notice to cancel appointments. A fee will be imposed if you do not notify the Practice twenty four hours prior to your appointment and/or if we receive no notice to cancel or reschedule your appointment. Our fees are as follows:

Established Patient No-Show Fee	$25.00
New Patient No-Show Fee	$50.00
Procedure No-Show Fee	$100.00

11. A $30.00 fee will be charged for any checks returned for insufficient funds. A credit card or cash will be required for any and all future payments. Checks will no longer be accepted under any circumstance.

12. There will be a minimum $25.00 administrative fee for any Medical Record or Patient Form requests. Pre-payment is required before any forms will be completed. Completed forms and records requests will be available for pickup within 7 to 10 days of fee paid.

13. Not all services provided by our office are covered by every plan. **Any service determined to not be covered by your plan will be your responsibility.**

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

______________________________ ______________ ____________

Signature of Patient or Responsible Party **Relationship** **Date**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize ______________________________ to release the following information from the health records of:

Patient Name: ______________________________ **Date of Birth:** ____________________

Covering the period of treatment from ____________________ to ______________________________

Information to be Released:

☐ History & Physical ☐ Discharge Summary ☐ Emergency Room ☐ Progress Notes

☐ Consultation Reports ☐ Cardiac Studies ☐ Imaging Reports ☐ Laboratory Reports

☐ Other (please specify): ______________________________

__________ I understand that this information may include references to treatments of drug or alcohol abuse, psychological illness, or test results for HIV/AIDS.
Please Initial

Purpose of Disclosure:

☐ Continued Health Care ☐ Personal Reasons ☐ Insurance ☐ Legal

☐ Other (please specify): ______________________________

This authorization shall remain in effect until such time as it is ***revoked in writing*** by the patient. A photocopy of this authorization is to be considered as valid as the original.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that redisclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless for complying with this Authorization for Release of Medical Information.

Fees will comply with all laws and regulations applicable to release of medical information.

______________________________ ______________________________
Patient Signature **Date Signed**

____
Relationship to Patient

Please release information to:

SC Pain & Spine Specialists, LLC | Phone: 843.839.7246 | Fax: 843.839.7323 | www.scpainandspine.com

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used or disclosed. It also explains how you may get access to this information. Please review this notice carefully. The privacy of your health information is very important to us.

USE AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to another physician or healthcare provider that may be treating you, or to any family member or friend that you may have designated.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of your PHI (Personal Health Information), or to request alternative means of communication to ensure privacy, such as only using home phone number or not contacting you at work.

Marketing Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages or letters).

PATIENT RIGHTS

Access: You have the right to obtain copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information as well as postage if you want the copies mailed to you. We will provide the information within 30-days of your written request.

Amendment: You have the right to request, in writing, that we amend your health information if you believe it is incorrect.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at an alternative location, you may submit a written complaint to us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Practice Administrator who serves as the Privacy Officer.

PATIENT ACKNOWLEDGEMENT

Patient Name (please print): ________________________________ Today's Date: ____________

Please read and acknowledge below with your signature:

I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES from SC Pain & Spine Specialists, LLC (or that it was made available to me but I did not wish to receive it) and I consent to the uses described within it.

____
Signature of Patient, Parent or Legal Guardian

GENERAL INSURANCE INFORMATION

Each insurance carrier has their own rules, policies, and procedures in order to allow payment for services. Below please find some of the most commonly used terms and definitions you should be aware of prior to receiving healthcare services from a Provider. It is your responsibility to know the terms of your plan prior to your visit in order to be prepared to meet the necessary requirements.

If your plan has a **deductible**, you must meet the deductible amount by paying the Provider *before* the insurance company will begin paying for any services you receive. If your deductible has been met, the carrier will then pay a percentage of the allowed service amount and an additional percentage may be due from the patient to the Provider (this is called **coinsurance**). The patient is also responsible to pay any **copay** required by their plan at every visit (this is separate from deductible and coinsurance amounts). Not every plan has all of these requirements which is why it is important to know about your individual plan.

Benefit Plan
A certificate of coverage, summary plan description, or other document or agreement which specifies the healthcare services to be provided or reimbursed for the benefit of a Participant (patient).

Deductible
A payment for Covered Services calculated as a fixed dollar amount that is the financial responsibility of the Participant to the Provider under a Benefit Plan prior to qualifying for reimbursement for subsequent healthcare costs under the Terms of a Benefit Plan.

Coinsurance
A payment that is the financial responsibility of the Participant to the Provider under a benefit plan for Covered Services that is calculated as a percentage of the contracted reimbursement rate for such services or, if reimbursement is on a basis other than fee-for-service amount, as a percentage of a plan-determined fee schedule or as a plan-determined percentage of actual charges.

Copayment
A payment that is the financial responsibility of the Participant to the Provider under a benefit plan for covered services - a fixed dollar amount.

Medically Necessary / Medical Necessity
Services and supplies that satisfy the Medical Necessity/Medical Policy requirements under the applicable Benefit Plan. No service is a Covered Service unless it is deemed medically necessary. You will be informed if a service is not covered and will be asked to sign an Informed Financial Consent Form stating that non-covered services are the responsibility of the patient and must be paid in advance of services rendered.