ANESTHESIA SERVICES OF LYNCHBURG, INC.
INTERVENTIONAL PAIN SERVICE
1922 THOMSON DRIVE, SUITE D
LYNCHBURG, VA 24501
Phone: 434-845-5493
Fax: 434-845-1099

OFFICE FINANCIAL POLICY

Thank you for choosing Anesthesia Services of Lynchburg as one of your health care providers. The members of the office staff are available to assist you in understanding our office policies. The following information is important and your understanding of this information will allow us to continue providing medical services to you.

Our office financial policy requires payment in full for all medical services rendered.

Payment is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your correct information and consent. If your insurance company has not paid your account within 90 days, the balance will automatically become your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary with your insurance.

We will be happy to file your claim with your health insurance plan so that the claim can be resolved promptly. If you are covered by one of the health insurance plans with which we participate, you will be billed for all co-payments and deductibles. We will also be happy to arrange a payment plan or provide a financial hardship application. Self pay patients are required to pre-pay 25% of the bill in advance. **We do not wait on payment from any pending litigation.**

We accept cash, personal check, money order, Visa and Mastercard. Returned checks are subject to a $25.00 return check fee. **Failure to give our office 24 hours advance notice of cancellation of your appointment will result in a $50.00 charge to your account.**

I (we) understand and agree (by signing below) that I (we) am (are) directly and fully responsible to Anesthesia Services of Lynchburg, Inc. for current payment of all medical bills for services rendered. In the event it is necessary for Anesthesia Services of Lynchburg, Inc. to turn an account over to its collection agent, then I agree to pay all costs of collection including the attorney’s fee, court costs, service of process cost, and interest until my account is paid in full.

Thank you for understanding our financial policy. Please let us know if you have questions or concerns.

X: ____ Date:____________________
Signature of Patient/responsible party