Portland Pain Solutions - Financial & General Practice Policies

Updated August 21, 2025

We do not prescribe benzodiazepines, opiates, or sedatives.

Initial Visit Requirements:

Bring photo ID, insurance card (if applicable), and a credit card for check-in if applicable.

Fees we would like to call your attention to:

No-show/Late Cancel** After 3 pm Prior Business Day: $45

Prior-Authorization Admin Fee: $20

Prior-Authorization Admin Fee (BCBS of MA): $100 (there are unique issues with this company)

Peer-to-Peer Call Admin Fee: $50

Soft-tissue fascia/nerve hydrodissection (per body region): $175 (prolo is $195)

Imaging Guidance for Injections (when not insurance-covered): $125

Exam Under X-ray: $125

****The purpose of our late cancel / no show fee is to partially offset the overhead of your empty slot on the schedule**. It's not a penalty for being sick, having a flat tire, etc. The fee applies to both new patient and follow up visits. Appointment cancellation requires a phone conversation with practice staff, a voicemail, text, or email with a timestamp BEFORE 3 PM the BUSINESS day prior to the scheduled visit. The no show/ late-cancel fee applies regardless of reason (again... even if you are sick, have a flat tire, etc), so be sure to cancel early if you are not 100% sure you can be at a visit on time. We need the entire appointment slot for your visit, so arrival more than 10 minutes after a scheduled visit is considered a no-show, and you will be rescheduled- so plan on arriving early for your visit.

Updates to these fees are posted on the check-in desk window. See the end of this section for other less common fees.

Credit Card on File:

Required for all patients to hold appointments, for insurance policies using copays, deductibles, or coinsurance, as well as prior-auths and no-show fees.

Authorized for (up to) $1500 to cover potential out-of-pocket costs after insurance processing of your claim.

Unexpected charges a few weeks after a visit often relate to balances calculated after insurance processing of claims- see the coinsurance and deductible example below.

Insurance-Billed Work:

Patients are responsible for understanding their insurance plan's rules, what copays, coinsurance, and deductibles are, and how this applies in their situation.

Patients are responsible for making sure insurance-required PCP referrals are in place prior to associated visits. Payment becomes your responsibility if insurance denies your claim for lack of the referral they require.

Patients are required to ensure that procedures are performed within the date range of their insurance authorization. Payment becomes your responsibility if you initiate scheduling outside the date range, we somehow fail to catch your mistake, and payment is subsequently denied.

Charges will apply post-insurance processing for any portion unpaid by the insurance company.

Insurance processing usually takes 3-4 weeks, at which point your credit card will be charged for the balance.

Example: If insurance pays $84 of a $105 service with a 20% coinsurance, the patient owes $21, which is 20% of the $105 insurance-contracted rate.

Example: if insurance pays $0 of a $105 service because the deductible hasn't been met, the patient owes the full $105 insurance-contracted rate.

Non-Insurance Billed Work:

Payment due at time of service.

We do not offer payment plans or Care Credit.

Some insurance companies ask that we have you sign a form ("ABN") stating that we informed you that a service is not insurance covered. Since payment for these services is due same-day, this will always be discussed before service is rendered. You will not be billed later for work you paid for at a visit. If you would like an invoice, the time to ask for one is when payment is made on the date of service.

Common Procedures Generally Covered by Insurance:

Epidural Steroid Injections

Medial Branch Blocks / Back or Neck RF Ablation

Joints & Bursa Injections

Kyphoplasty / Spinal Cord Stimulators

Common Procedures Generally Non-Covered:

Soft-Tissue Hydrodissection of Fascia and Peripheral Nerves (all patients except Worker's Comp)

Prolotherapy

Peripheral Nerve Blocks (all commercial insurance)

Knee RF Ablation: (all commercial insurance, and commercial Advantage plans with the exception of Martin's Point and United MDC)

Shoulder/Hip/Sacroiliac RF Ablation

Stellate Blocks (uses other than CRPS)

Ketamine Infusions (all patients except Worker's Comp)

Platelet-Rich Plasma (all patients except Worker's Comp)

Personal Injury

Non-Insurance Personal injury cases require payment at time of service, we do not perform work based on letters of protection or liens.

Misc Administrative Fees:

Mailed Documents, Lost Cards/papers/disks: $15

Special Document Preparation - This is anything involving more work for us than simply selecting a document, printing it, and handing it to you in the office. (Example, "I want all my bills reprinted on CMS-1500 forms and sent to a different insurance company"): $5 per document, $15 minimum)

Special Letters: Varies, starting at $25/letter, plus $25 per requested revision (example, "I need a letter for my airline saying I can't go on the trip because of pain", this would be $25; "wait, the airline said it has to have my ICD-10 code and you didn't include that", this is a revision- thus an additional $25)

Special Forms: I do not offer completion of all special forms, but if I do, it's $25 per page, $50 minimum.

Returned Check Fee: $30

Copy of Medical Records: $15

Conduct:

The following behavior will result in permanent discharge from the practice:

• Rude or abusive behavior toward staff, by patients or their accompanying family members/guests

• Expressing yourself in a manner that creates a hostile relationship with staff

• Creating the impression of a threat to any staff member or the practice

• Making excessively frequent, unreasonable demands of staff time in the office, over the phone, or electronically

• No-showing a first visit, or a repeated pattern of no-shows on follow-ups

• History of any of the above with other medical providers, evinced by documentation we review from other practices and/or institutions

• Inability to abide the terms of this agreement

General Consent to Care

I authorize Portland Pain Solutions and its employees to access **all of my medical records** wherever they may be located, and conduct the necessary medical evaluations to determine suitable treatments and/or procedures for any identified conditions.

I understand that if **additional testing, invasive, or interventional procedures** are recommended, I will be asked to review and sign additional consent forms before proceeding with the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent voluntarily to their contents.

This consent allows us to perform **reasonable and necessary medical treatments** in the office that are not covered by separate procedure consent forms. For instance, if you faint in the office, this consent permits us to provide immediate treatment and seek emergency assistance if needed.

By signing below, you acknowledge that (1) you intend this consent to be ongoing, and (2) **it will remain fully effective until revoked in writing**. You have the right to discontinue services at any time. You also have the right to discuss your treatment plan with your physician, including the purpose, potential risks, and benefits of any tests, procedures, or medications prescribed to you. If you have any concerns about any recommended tests or treatments, we encourage you to ask questions.

Assignment of Benefits

I hereby assign all medical and surgical benefits to which I am entitled, including all government and private insurance plans or other payers, to Portland Pain Solutions and the medical professionals caring for me during my treatment in this office. Payments for services rendered should be made directly to Portland Pain Solutions or other associated providers as appropriate. I understand that I am responsible for any charges not covered by insurance. This assignment will remain in effect until I revoke it in writing and receive a written acknowledgment of receipt.

Release of Billing Information

I authorize the release any information necessary to insurance carriers regarding my illness and/or treatments in order to process insurance claims generated in the course of examination or treatment. I authorize a photocopy of my signature to be used to process insurance claims. This release is valid until I revoke it in writing and receive a written notice in response that it has been revoked.

Privacy Policy / HIPAA Notification

This notice outlines how your health information may be used and disclosed, and how you can access this information. Please read it carefully as your privacy is important to us.

Our Legal Obligation:

We are mandated by federal and state laws to protect the privacy of your health information. This notice explains our privacy practices, legal obligations, and your rights regarding your health information. We are required to adhere to the practices outlined in this notice until it is updated. We reserve the right to modify our privacy practices and the terms of this notice at any time, as permitted by law. Any changes will apply to all health information we maintain, including past and future information. Before implementing significant changes, we will update this notice and provide the new notice at our practice location, as well as upon request. You can request a copy of this notice at any time.

Authorization:

In addition to the uses described here, you can authorize us in writing to use your health information for other purposes. You can revoke your authorization in writing at any time, though this will not affect uses or disclosures made while the authorization was in effect. Without written authorization, we cannot use or disclose your health information for reasons outside those described in this notice.

Security:

You will be promptly notified if your health information security is compromised.

Uses and Disclosures of Health Information:

Treatment: We may use or share your health information for treatment purposes, such as sharing it with a physician or pharmacist.

Payment: Your health information may be used to obtain payment for services, such as sending claims to your health plan.

Healthcare Operations: We use your information for operations, including quality assessment, staff evaluations, and training programs.

To You or Your Personal Representative: We are required to provide your health information to you and may share it with your representative if you agree.

Involvement in Care: We may use or share your information to inform family or other representatives involved in your care about your location and condition, using professional judgment to determine when this is appropriate.

Disaster Relief: Your health information may be used to assist in disaster relief efforts.

Marketing: We will not use your health information for marketing without written consent.

Legal Requirements: Your health information may be disclosed as required by law.

Public Health: We may disclose information for public health activities, such as reporting diseases, abuse, or for health oversight.

Deceased Individuals: Information may be shared about deceased individuals as authorized by law.

National Security: Health information may be disclosed to military or federal officials as required for security purposes.

Appointment Reminders: We may contact you with reminders for appointments.

Your Rights:

Access: You can access your health information and request copies. We will provide copies in the format you request if possible and may charge a reasonable fee for copies and postage.

Disclosure Accounting: You can request a list of disclosures of your health information made for purposes other than treatment, payment, and healthcare operations.

Restrictions: You can request additional restrictions on the use of your information, though we are not required to agree to all requests. We must comply with requests to restrict disclosures to health plans if the service is paid out-of-pocket in full.

Alternative Communication: You can request communication through alternative means or locations.

Amendment: You can request to amend your health information, which we may deny under certain conditions.

Non-disclosure: We will not disclose information to insurance companies for services paid out-of-pocket upon request.

Complaints:

For questions or concerns about our privacy practices, contact us using the information provided at the end of this notice. You can also file a complaint with the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. We support your right to privacy and will not retaliate against you for filing a complaint.

I have reviewed the attached Financial & General Practice Policies, General Consent to Care, and Assignment of Benefits, and agree to the terms of each. I have also had a chance to review the Privacy Policy / HIPAA Notification and understand its contents.

_____ _____

Patient/Guarantor/POA Date