The Back and Neck Clinics

BELLAIRE • PEARLAND

Abraham G. Thomas, M.D., P.A.

BOARD CERTIFIED IN PAIN MEDICINE**AMERICAN BOARD OF ANESTHESIOLOGY

Patient name:____

Welcome and thank you for choosing The Back and Neck Clinics. We are committed to providing quality medical care.

Insurance

Dr. Abraham G. Thomas, M.D. will file claims directly with your insurance carrier for services. Insurance verification does not guarantee payment. Payment is required at the time of service.

Contracted Managed Care Plans (HMO, PPO, POS, etc)

Each time you make an appointment with Dr. Abraham Thomas, it is your responsibility to confirm Dr. Abraham Thomas and any providers utilized by Dr. Thomas are currently under contract with your plan and that you have obtained the necessary referrals as needed. We allow 45 days from the date a claim is filed by our office for the insurance company to send payment. If the insurance carrier has not paid within this time, you are responsible for the entire balance due. We will not become involved with any disputes between you and your insurance company regarding any unpaid services. You are responsible for any unpaid balances on your account, to be made to this office within a timely manner.

Medicare

Is accepted as an assignment of benefits.

Medicaid

Traditional only, is accepted in this office as a Secondary Payer.

Method of Payment

For your convenience, we accept all major credit cards, as well as cash and personal checks under $200.00. There is a $50.00 fee for all returned checks. After you have written one insufficient check, no personal checks will be accepted. Only cash and major credit cards will be accepted.

No Show Appointments

If you must cancel or need to reschedule an appointment, we ask that you notify our office at least 24 hours prior to your appointment.

Attorney/Litigation

Dr. Abraham G. Thomas does not accept letters of protection (LOP) from attorneys involved in any type of litigation. It is your responsibility to notify this office of any pending litigation.

THIS DOES NOT APPLY TO WORKER'S COMPENSATION PATIENTS

I, the undersigned, attest that I have read all the information above, understand and agree to all of the requirements.

______________________________ ____________________

Signature **Date**

______________________________ ____________________

Witness Signature **Date**