

**PAIN THERAPEUTICS PROFESSIONAL ASSOCIATION**

**Abraham G. Thomas, M.D.**

**5420 West Loop South, Ste. 4300**

**Bellaire, Texas 77401**

**Phone: (713)797-0876 Fax: (713)797-1601**

Welcome and thank you for choosing Pain Therapeutics, P.A. 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 make sure Dr. Abraham Thomas is currently under contract with your plan and that you have obtained the necessary referrals when needed. We allow 45 days from the date a claim is filed by our office for the insurance company to pay. If the insurance carrier has not paid within this time, you are responsible for entire balance. 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 this office.

**Method of Payment**

For your convenience, we accept all major credit cards, as well as cash and personal checks. There is a \$50.00 fee for all returned checks. After you have written one bad check, no more 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, you must notify our office at least 24 hours prior to your appointment. If you fail to do so, a \$50.00 charge will be posted to your account.

**Attorney/Litigation**

Dr. Abraham G. Thomas does not accept letters of protection (LOP) from attorneys involved in any type of litigation. If you are involved in legal matters and are classified as a litigation account with our office, you will be responsible for full payment for services rendered by Dr. Abraham G. Thomas.

You will be held responsible for your account balance, should any false information be give to this office.

**THIS DOES NOT APPLY TO WORKERS' 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**

\_\_\_\_\_  
**Date**