



Updated Sept 25, 2026

Portland Pain Solutions - Financial & General Practice Policies

Practice Scope and Patient Responsibilities

Our practice is primarily focused on interventional pain management for musculoskeletal and neurological conditions, as well as certain psychiatric conditions that overlap with our procedural capabilities.

Our practice does not prescribe opioids, benzodiazepines, or sedative medications.

As a small specialty practice, we accept and continue care for patients who are able to participate reliably in their treatment. At a minimum, patients must be able to:

Communicate clearly and appropriately with our office by telephone and during visits.

Maintain reasonable and timely communication with the practice.

Keep scheduled appointments and arrive on time.

Participate in required electronic health record and other electronic communications or data-management processes.

Maintain their financial obligations to the practice, including timely payment of balances.

Participate appropriately in the treatment process and maintain reasonable expectations regarding the care and services we can provide.

Patients who are unable or unwilling to meet these basic requirements will not be offered scheduling.

Initial Visit Requirements:

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

Fees We Want to Highlight

The following fees are uniformly applied when applicable:

Fee Type | Amount

No-Show / Late Cancellation Fee | \$50 (follow up) | \$100 (new patient)

Standard Prior Authorization Administrative Fee | \$20



Complex Prior Authorization Administrative Fee (uncommon) | \$100

Peer-to-Peer Call Administrative Fee | \$75

No-Show / Late Cancellation Fee

Our no-show / late-cancellation fee is intended to partially offset the overhead cost of an unused appointment slot. It is not a penalty for illness, transportation problems, emergencies, or other circumstances. The fee applies to both new patient and follow-up visits.

To avoid this fee, appointment cancellation must be completed before 3:00 PM on the prior business day by one of the following methods:

Phone conversation with practice staff

Time-stamped voicemail

Time-stamped text message

Time-stamped email

If you press option 2 during an automated reminder call to reschedule, you must still speak with staff or leave a time-stamped voicemail before the deadline. Selecting the automated option alone does not complete cancellation.

The no-show / late-cancellation fee applies regardless of the reason for the missed or late-cancelled appointment. Please cancel early if you are not fully sure you can attend on time.

Because the full appointment slot is reserved for your visit, arrival more than 10 minutes late may be treated as a no-show, and the appointment may need to be rescheduled.

Prior Authorization Administrative Fee

A standard prior authorization administrative fee applies for relatively straightforward electronic prior authorizations submitted through systems such as Carelon, EviCore, Evolent, Cohere, or similar platforms.

Some insurers require substantially more administrative work, including prolonged phone calls, repeated documentation requests, multiple representatives, phone trees, disconnects, and delays that significantly disrupt practice operations. When authorization work becomes unusually time-intensive, the complex administrative fee applies.



BCBS of Massachusetts Prior Authorizations - known complex prior-auth

Prior authorizations through BCBS of Massachusetts often involve unique administrative burdens, including extended processing times, repeated paperwork exchanges, and delays that may last several weeks.

For this reason, a higher administrative fee applies to BCBS of Massachusetts prior authorization work. Patients with this insurance must agree to this fee before authorization-related work is performed.

Florida Blue - known complex prior auth, if they can be completed at all

Peer-to-Peer Call Administrative Fee

An administrative fee applies when an insurer or patient request us to do a physician-to-physician review / peer-to-peer call as part of the authorization or appeal process.

Fee Updates

Updates to these fees are posted at the check-in desk window. Other less common fees may also apply and are listed at the end of this section.

Credit Card on File

A valid credit card on file is required for patients with insurance plans that may involve copays, deductibles, coinsurance, prior authorization requirements, or other patient-responsibility balances like our admin fees. The card on file may also be used for applicable no-show or late-cancellation fees if those fees apply under the practice's scheduling policy.

By signing this Financial Policy and providing a card on file, you authorize Portland Pain Solutions to charge your card for patient-responsibility balances after insurance processing, usually up to a maximum of \$1,500, including copays, deductibles, coinsurance, non-covered services, and other balances determined to be the patient's responsibility.

Charges may occur several weeks after a visit because insurance claims must first be processed by your insurance carrier. For example, a balance may become due after your insurance applies the visit to your deductible or calculates coinsurance.

You may withdraw your card-on-file authorization at any time by submitting a written request with a date and time stamp, such as a patient portal message, email, or mailed letter with a postmark. A withdrawal request is not effective until Portland Pain Solutions has received the request, processed it, and confirmed the cancellation in writing.



Charges already processed, pending, or owed for services rendered before the confirmed cancellation remain the patient's responsibility.

If you later dispute or charge back a valid patient-responsibility charge, the chargeback does not eliminate the underlying balance owed for services rendered. If you claim that you withdrew your card-on-file authorization before a charge was processed, you agree that you must provide written, dated proof of that withdrawal request and the practice's written confirmation of receipt/cancellation.

Insurance-Billed Work

Patients are responsible for understanding their own insurance benefits, including copays, deductibles, coinsurance, referral requirements, prior authorization rules, coverage limits, and network requirements.

While Portland Pain Solutions will make reasonable efforts to assist with insurance billing and authorization workflows, insurance coverage is not a guarantee of payment. Any amount not paid by insurance may become the patient's responsibility.

Patients are responsible for ensuring that any insurance-required PCP referral is in place before the associated visit or service. If a claim is denied because a required referral was not obtained, the balance may become the patient's responsibility.

Patients are also responsible for understanding when their insurance requires prior authorization. This is especially important after any insurance change, since authorization requirements may differ by plan. If a service requires prior authorization and authorization is not obtained, or if coverage is denied for authorization-related reasons, the balance may become the patient's responsibility.

Procedures must also be scheduled and completed within the approved authorization date range. If a patient schedules or proceeds with a service outside the authorized date range and insurance denies payment, the balance may become the patient's responsibility.

After insurance processes a claim, any remaining patient-responsibility balance, including copays, deductibles, coinsurance, or non-covered amounts, will be charged to the card on file in accordance with the Credit Card on File Policy.

Insurance processing typically takes 3-5 weeks, though timing may vary by insurer.

Coinurance example:

If the insurance-contracted rate for a service is \$105 and the plan requires 20% coinsurance, insurance pays \$84 and the patient owes \$21.



Deductible example:

If the insurance-contracted rate for a service is \$105 and the patient has not met their deductible, insurance may pay \$0 and the patient may owe the full \$105 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

Prolotherapy

Peripheral Nerve Blocks

Knee/Shoulder/Hip/Sacroiliac RF Ablation

Stellate Blocks (uses other than CRPS)

Ketamine Infusions (all patients except Worker's Comp)

Platelet-Rich Plasma

Calmare

Medicare Update on Peripheral Nerve Blocks & RF



Starting in October 2026, Medicare is making large changes in their coverage of peripheral nerve blocks. These are changing to a non-covered service. For example, occipital and pudendal nerve blocks, as well as genicular blocks and knee RF are now explicitly non-covered. Neck and low back RF are still covered by Medicare.

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. A pattern of 3+ timely, but repeated cancels will likely result in discharge.
- Chargebacks on your credit cards for legitimate bills
- 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

We make good faith efforts to do right by our patients in every way. If you are upset, angry, or confused about something- there is likely a misunderstanding. If you think that might be what's going on, please ask.