SOUTHWEST SPORT & SPINE CENTER, INC.

OFFICE FINANCIAL POLICY

Patient Name: ______________________________ **Date of Birth:** __________

_____ **BASIC POLICY:** Payment for service and supplies are due in full at the time of service.

_____ **FOR PATIENTS WITH INSURANCE:** As a convenience to our patients, we verify benefits and bill most insurance carriers for you. We will also bill most secondary insurance companies for you. Patient portion and deductibles are due at the time of service. If an insurance carrier has not paid SWSSC within 60 days of billing, payment is due in full from you.

_____ **MEDICARE PATIENTS:** We will bill Medicare for you. We will also bill secondary insurances for you. All deductibles or patient portions are due and payable at the time service is provided. Patient is responsible for seeing their physician within 60 days of first visit and every 30 days thereafter.

_____ **MEDICAID PATIENTS:** All medicaid patients must provide a current, valid card before being seen. Patient is also responsible for informing provider of any changes in MCO and Primary Care Doctor. **IF YOU MISS 2 APPOINTMENTS WITHOUT 24 HOUR NOTICE YOU WILL BE DISCHARGED AND YOUR INSURANCE AND DOCTOR WILL BE NOTIFIED**

_____ **WORKERS COMPENSATION:** If your injury is work-related, we will need the case number and carrier name prior to your first visit in order to bill the workers compensation insurance company.

_____ **MISSED APPOINTMENTS:** In fairness to other patients and the providers, we require at least 24 hours notice to cancel appointments. We reserve the right to charge the following cancellation fee: **$25.00 - Regular Visit, $50.00 - Initial Visit. In instances of repeated non-compliance with your scheduled visits we also reserve the right to discontinue care and will inform your physician.**

MEDICARE PATIENTS: SIGNATURE ON FILE I request payment of authorized Medicare benefits be made either to me or on my behalf to Southwest Sport & Spine Center, Inc. for any services furnished me by the listed provider. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the CMS-1500 form or else where on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. A copy of this signature is valid as the original.

Patient's Name (Print)

Patient's Signature

Patient's Medicare No. Date:

Southwest Sport & Spine Center, Inc.
2404 S. Locust Street, Suite #5
Las Cruces, NM 88001
575-521-4188

Witness

Patient Responsibility amounts are an estimate and will be determined by insurance at time of claim processing. Any difference in these amounts (ie Deductibles & Co-Insurance) will be billed to the patient at the completion of insurance processing. **The patient is ultimately responsible for all fees**. The undersigned certifies that he/she has read the foregoing, received a copy of thereof, and is the patient, the patient 's legal representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms. A copy of this signature is valid as original

_______________ Date

______________________________ PATIENT/PARENT/GUARDIAN/CONSERVATOR

______________________________ Witness

IF THE AMOUNT AND/OR FREQUENCY OF PAYMENT IS A CONCERN, PLEASE ASK ABOUT OUR PAYMENT PLANS.

Deductible	__________	__________	Patient Initials
Co-Insurance	__________	__________	Patient Initials
Copayment	__________	__________	Patient Initials

ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurance(s) please read and sign below. I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to: Southwest Sport & Spine Center, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. A copy of this signature is valid as the original.

Signature Date