FINANCIAL POLICY

Benefits are determined once a claim is received by your insurance company. New Mexico Medical will provide the service of billing your medical insurance company; however, as the patient and/or responsible party, you are responsible for providing us with **ALL** the **CORRECT** and **COMPLETE** information regarding medical insurance coverage at the time of service. It is also the responsibility of the patient and/or responsible party to pay for all co-payments, deductibles, and/or co-insurance amounts, if required by your insurance policy. If the insurance company denies the claim for services rendered due to reasons for which we cannot appeal, you understand that the balance will then become your responsibility.

As a cash paying patient, you are aware that half of the payment for services rendered are due at the time of service and payment arrangements may be made for the remaining balance.

A non-sufficient funds (NSF) fee of $35 will be applied to any returned check and then we will only accept cash, credit card, or money order for any and all payments thereafter.

If you fail to pay any amount owed within the time allotted, your account will be sent to a collections agency and you understand that you will then owe the amount for services rendered plus any and all collection costs and attorney's fees.

ASSIGNMENT OF BENEFITS

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare Beneficiary, to New Mexico Medical and or/it's affiliated entities or otherwise at its direction.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical or any other information to New Mexico Medical, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by New Mexico Medical. A copy of this authorization will be sent to my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by New Mexico Medical.

I HAVE READ, UNDERSTAND, AND AGREE TO THIS FINANCIAL POLICY, ASSIGNMENT OF BENEFITS, AND AUTHORIZATION TO RELEASE INFORMATION

Print Patient/Responsible Party Name:_____

Date Of Birth:_____

Social Security Number:_____

Patient/Responsible Party Signature:_____

Date:_____