SXM SYMPTOM MEDICINE
Pain Medicine, Palliative Care, Anesthesia

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PATIENT AGREEMENT OF FINANCIAL RESPONSIBILITY

Dear

Health care polices, including Medicare PPO, EPO and governmental endorsed health care plans, do not pay for everything. Even if you and your health care provider have good reason to think you need it, some medical services are not covered. Furthermore, coverage is not automatic and pre-authorization maybe a stipulation of your health care plan for medical services. You will need to call your insurance provider, confirm coverage and obtain preauthorization for all services. Once, you have been approved for services, the Clinic can schedule your appointment and will inform you of your financial responsibility. You will be fully responsible to Symptom Medicine for all charges that are not paid by your insurance company or other sources. Understand if preauthorization is not obtained, you are denied services, or your visit precedes or exceeds the effective dates assigned by your health care plan, you will be financially responsible for all incurred fees. However, if you wish not to obtain pre-authorization for services or wish to waive all of your health care policy benefits, you will be considered as an uninsured and non-covered patient for all service.

Before any appointment can be scheduled, the Clinic requires that you pay for any deductable, co-insurance, non-covered services, co-payments, and fee for services. As noted above, you must obtain the necessary pre-authorization from your health care plan prior to any service. If you do not have proof of insurance, recommended services are not covered or you waive all of your health care policy benefits, you may still receive services with the understanding that any non-covered or uninsured medical services will need to be paid in full before your appointment. No matter what type of payment you choose or insurance you have, you agree to accept full responsibility to pay your account in accordance with the regular physician service rates and terms of the Clinic.

Fee for Services & Physician Service Rates: The cost of physician services for uninsured patients and non-covered insurance services only apply to services provided by a SxM physician and is at a rate of $600.00 per hour. This rate does not include and is not limited to facility fees, medication cost, nursing services, physicians or health care provides not employed by SxM, hospital fees, laboratory fees, radiographic studies, radiographic studies, psychological evaluations, administrative fees, and so forth. If a discount for cash payments is offered, a discount cannot be applied to any payment related to third payor, fees outside SxM physician services, insurance policy or patient responsibilities, which include but are not limited to co-pays, co-insurance, deductable and so forth.

For each occurrence, the undersigned agrees to pay interest on all such delinquent amounts at the rate of 18% per annum or 1.7% per month, and a late payment fee of $30.00, plus all the actual legal and other costs associated with collecting said delinquent balances. All accounts with outstanding delinquent payment and bills greater than 90 days will be reported to the Credit Bureau unless prior agreements are made and agreed upon. Insufficient funds for checks will incur a $30.00 fee per event and it will be charged to your Clinic account. For any appointment that is not cancelled 24 hours in advance, the fee is $50.00. These charges and fees cannot be billed to any health care policy or third party payor.

I waive all rights and benefits of my health care policy and wish to be considered an uninsured and non-covered patient for all service while I am a patient at Symptom Medicine. I understand that my insurance company will not be billed for any service rendered by Symptom Medicine and I will be personally responsible for all payments and account balances.

Signature	Printed Name	Date &time

Financial responsibility agreement by patient and patient representative: I agree to accept joint and several financial responsibility with Patient for services rendered to Patient and accept the terms set forth above and received a copy.		
Patient Signature	Name:	Date and Time
Patient Representative Signature	Name: and Relationship	Date and Time
Witness Signature	Name:	Date and Time