SWPT ANESTHESIA PC
Financial Agreement

We strive to provide high quality, cost effective care to our patients. Our first priority is to you, our patient. As we are sure you understand, to continue providing care we must receive prompt payment for the services rendered. Your assistance in seeing that your account is kept current is appreciated!

Please read the following financial agreement initial, sign, and date at the bottom:

This office will accept the following methods of payment for services rendered: **Visa/MasterCard/Debit Cards/Cash/ Money Order/Cashier's Check. We DO NOT accept personal checks.**

Responsible parties without insurance coverage agree to pay for services at time of visit. All procedures must be paid in full **prior** to services rendered. We offer a 5% discount to patients WITHOUT insurance coverage when paying for their procedure with CASH and 1 week PRIOR to their surgical appointment. This discount will not be offered the day services are rendered.

We do not provide in-house financing or payment plans.

This office will not be involved with any third-party liability cases. We do not file with automobile or homeowner's insurance liability policies. Services are to be paid in full by you and you can seek reimbursement from the liability insurance company. We do file MEDICAL LIENS in compliance with A.R.S. 33-931 *et. seq.* to insure that we receive full payment for our usual and customary services. We do not agree to pay any part of the attorney's fees or cost you or your attorneys incur in preparing or pursuing any claim or suit against the individuals or parties who may have caused the injuries for which we are treating you. By signing this agreement, you agree to work with this office, our billing and legal representatives to keep us informed of the status of any suit and to insure that the lien is honoured and full payment is made from the suit or claim proceeds and waive any claim for contribution under the "Common Fund" doctrine or any other equitable apportionment claims or theories recognized by Arizona law. If your injuries were caused by a third party and we have filed a MEDICAL LIEN, we expressly reserve the right not to bill any private, government or public/private first party medical insurance provider..We do not accept Medicare A ,B, or C in those instances when your injury is caused by another and we file a medical lien pursuant to A.R.S. 33-931 et. seq.

We do file UCC liens in compliance with ARS 47-1101,et.al. to insure our bill is paid by your applicable underinsured motorist coverage, uninsured motorist coverage, and/or medical payment coverage through your applicable motor vehicle insurance policy. By signing below you grant us a security interest in those insurance coverages.

It is our policy to submit any insufficient funds to the appropriate legal authorities. A $25 charge will be added to your account for each check returned.

You agree to pay all costs of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%, such contingency fee to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.

In cases of divorced parents, the parent bringing the child will be deemed responsible for payment. We cannot become involved with personal issues between divorced/separated spouses. It is their responsibility to coordinate payment for services rendered and see that payment of the estimated patient portion is paid in full prior to those services. We will not make another party responsible for the account without their written consent.

All patients are charged the same for services rendered. This office does not accept reasonable and customary charge calculations by outside parties, unless this office is a participating provider. Any adjustments/write-offs will be applied upon receipts of payment and EOBs.

Patients who miss a service or follow-up appointment, will be billed a $50 No-Show fee. This is not billed to your insurance company. All post-op appointments which are missed (no-show) will be assessed a $10 fee. This also is not billed to your insurance company. If you must cancel an appointment we require at least 24 hours notice.

Patients with Insurance – Please read the additional policies:

The most common misconception concerning insurance is that your policy will cover the total cost of services rendered. Insurance is designed to reduce your out of pocket cost, but usually will not eliminate it entirely. Your portion is due at the time of service.

Your service treatment is not dictated on what your insurance will cover. Together, SWPT ANESTHESIA, PC and you create your treatment plan based on what your current medical needs are. We cannot limit your care to just what is covered by your insurance plan. Every plan is different and each insurance company determines what is covered. Just because a particular service is not covered does NOT mean you do not need it.

Insurance is filed as a courtesy to you and coverage does not relieve you of the financial responsibility, nor suspend payments until the insurance has paid.

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Insurance will only be filed for plans that we are provided with at the time of service. We will not "back file/retro-file" any claims. You must provide all insurance information at the time of service. You are responsible for filing any claims with insurance plans we were not made aware of.

If your insurance policy requires a referral, that must be obtained prior to the appointment. We will not obtain "retro" authorizations for services not authorized in advance by the insurance company. It is the patient's responsibility to know if their insurance plan requires a referral from their primary care doctor.

If no insurance payment has been received within ninety (90) days of service, the patient is fully responsible for payment of the account. Please contact your insurance company to ensure your benefits are paid on your behalf.

Any unpaid amount not covered by your insurance must be paid in full by the responsible party no later than 60 days following receipt of the explanation of benefits from your insurance company

If payment has not been made to an account ninety (90) days after receipt of the explanation of benefits, and no contact or appropriate arrangements have been made, the account will be referred to the necessary legal authorities and credit bureau service.

Insurance coverage will be verified at the time of service. You must provide this office with an insurance card or proof of coverage. If coverage is unable to be verified, you are responsible for all charges incurred.

Upon verification of insurance benefits, we will attempt to estimate your portion of fees due. You are responsible for any co-insurance amounts **prior** to services rendered.

We cannot, by Federal law, discount your portion as determined by your insurance company.

If there is any other payment on the responsible parties part or the insurance company's part over the charges submitted, we will refund the difference. This takes about 30-60 days to process.

Responsible parties with insurance coverage can either:

File insurance yourself and pay us in full directly the day services are rendered. We will assist you with your paperwork.
Have us file your insurance. We will only file with 2 insurance plans. Filing of any additional plans will be your responsibility. You **MUST** have on the day of your appointment:
Insurance card with Subscriber's information
Photo ID (We do not file ANY insurance without a photo ID – Driver's license, Military ID)
The co-payment and deductible (as applicable) the day services are rendered. Co-payment can vary with insurance plans.

If your injuries were caused, or believed by you to have been caused by any other person or entity, you will immediately provide us with the name, address, phone number(s), e-mail address and insurance information of that person or entity and their insurance company. If you are represented by an attorney, you will immediately provide us with the name and contact information of that attorney and provide him with a copy of this agreement and the MEDICAL LIEN we have filed and sent to you.

Please read regarding estimate of benefits for services rendered:

We are not privileged to all insurance plans limitations and exclusions. You, as the beneficiary of the insurance policy,

are responsible for knowing all policy limitations and exclusions. The contract for benefits is between you and your insurance company; our only relationship is with you, the patient. We will prepare an **estimate** of insurance payment and your responsibility. This is prepared using information provided by your insurance plan's representative. We only use the information they provide us with, so if the information is not current, inaccurate, or lacking in detail, that will affect the treatment plan estimate we provide you with. Neither we, nor the insurance company, can guarantee the estimated payment amounts. Please understand that the estimate generated is provided as a courtesy. We will assist you in understanding your benefits, but are not responsible for your benefits or what is ultimately paid by your insurance plan. Any discrepancies should be addressed with your insurance company as they make the final determination of benefits provided, not us. You are responsible for verifying that all waiting periods have been satisfied prior to surgery. We cannot be held to the estimate of insurance benefits as it is only an estimate based on information provided on the day it is generated. Annual maximums, deductibles, and percentages of coverage may be different on the day of surgery based on care received by other practitioners and the medical necessity of the procedure as determined by your insurance company. SWPT ANESTHESIA PC does not determine medical necessity for your insurance company, but will assist in providing justification for services rendered to your insurance company to assist in determination of benefits. You, as the patient, are ultimately responsible for the full amount of the surgical cost.

Remember, insurance is filed solely as a courtesy to our patients.
Please help us to keep this service available to all patients.

I, (please print)_____ have read and agree to the above financial policies. I understand it is my responsibility to pay any fees to this office.

Signature_____ **Date**_____

If you have insurance, you must sign below:

I authorize release of any information relating to this claim. I understand that I am financially responsible for all costs of treatment. I hereby authorize payment of medical benefits, otherwise payable to me directly, to the below named entity:

SWPT ANESTHESIA PC
14301 N. 87th Street, STE 102
Scottsdale, AZ 85260
(P) 480-351-8188 (F) 480-351-8187

Signature_____ **Date**_____

MVA/PI INFO

Patient: _____ DOB: _____ DOL: _____

Mailing Address: _____

Parent/Guardian Name(if 17yrs or younger):

Mailing Address: _____

DRIVER / PASSENGER / PEDESTRIAN / SLIP-FALL / OTHER: _____

City, State Accident Occurred: _____ Report? YES / NO

1ST PARTY CARRIER: _____ Phone: _____

Policy Holder: _____ Policy #: _____

Open Claim? YES / NO ...If yes: MEDPAY / UM / UIM

*Medpay claim#: _____ Benefits exhausted? YES / NO

Adjuster: _____ Direct line: _____

Claims Mailing Address: _____

Claims Fax #: _____

*Uninsured or Under-insured Motorist claim#: _____

Adjuster: _____ Direct line: _____

Claims Mailing Address: _____

3rd PARTY CARRIER: _____ Phone: _____

Insured/At-fault: _____ Policy: _____

Claim #: _____

Adjuster: _____ Direct line: _____

Claims Mailing Address: _____

Liability Established? YES / NO 3rd Party Accepted? YES / NO %: _____

ATTORNEY: _____ Phone: _____

Law Firm: _____ Fax: _____

Address: _____

Paralegal: _____ Ext: _____

E-Mail: _____

HEALTH INSURANCE: _____ Can we bill this? YES / NO

Patient Signature _____ **Date** _____

SWPT Anesthesia PC
14301 N 87th Street, Ste 102
Scottsdale, AZ 85260
(p) 480.351.8188 (f) 480.351.8187

Attorney or Third Party Insurance/Guarantor:

_____
_____
_____

RE:COMMON LAW MEDICAL LIEN OF SWPT ANESTHESIA, LLC

PATIENT NAME:
Patient Address:
Account No.:
Date of Birth:
Date of Injury:

I,_____, herby authorize _____ to furnish SWPT Anesthesia PC and my attorney (if one retained) with a full report of any and all examinations, diagnosis, and medical treatment provided to me arising from the accident in which I was involved.

I hereby authorize and direct you and my attorney (if one is retained) to pay directly to SWPT Anesthesia PC any and all sums as may be due for medical services rendered to me both by reason of said accident and by reason of any other medical services and/or amounts due to SWPT Anesthesia PC. You are to withhold the sum due to SWPT Anesthesia PC from any settlement, judgment or verdict as may be necessary to adequately protect and compensate it. I herby further give a lien on my case to SWPT Anesthesia PC against any and all proceeds of settlement, judgment verdict OR insurance including, but not limited to, underinsured motorist coverage, uninsured motorist coverage, or motor vehicle medical payment coverage which may be paid to you and my attorney (if one is retained) as the result of all injuries for which I have been treated for or connected therewith. This lien may be signed in parts and have the same force and effects as though executed in one document. Any photocopy of the executed lien shall have the same force and effect as the original.

Nothing in this document prohibits SWPT Anesthesia PC from filing a statutory medical lien pursuant to A.R.S. 33-931.et al.

I fully understand that I am directly and fully responsible to SWPT Anesthesia PC for all services rendered to me and any resulting billing and/or charge due and owing. I understand that this agreement is made solely for SWPT Anesthesia PC's additional protection and in consideration of pending payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover.

I acknowledge my agreement to the content contained herein through signature below. I have been advised that if I do not agree to the contents herein, SWPT Anesthesia PC will declare my entire balance due and owing at time of medical service and/or treatment rendered.

_____

Patient Signature **DATE**