FAMILY AND SPORTS MEDICINE INSTITUTE OF NJ

"INSPIRING ACTIVE AND HEALTHY LIVES"

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Patient Financial Policy Agreement

- I will present proof of Insurance coverage at every visit
- I understand it is my responsibility to be educated about the benefits and limitations of my Insurance policy
- I understand my insurance policy is a contract between me and my insurance company. In the event they do not pay for services rendered to me which may include vaccinations, injections and durable medical goods, I am financially responsible for payment for those services.
- I understand that my account may be sent to a professional collection agency if payment is not rendered within 90 days from the billing date and in that event my relationship with FSMINJ may be terminated.
- I understand that if I disagree with any charges or would like to request an adjustment be made on my invoice or claim, I must contact the billing office in writing within 30 days of the billing date.
- I understand that it is my responsibility to provide FSMINJ with any information necessary to be paid for services rendered to me or anyone covered under my insurance policy or I will be responsible and will pay the balance in full

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

- I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.
- I hereby authorize FSMINJ to apply for benefits on my behalf for covered services rendered by my family physician, or by his/her order. I request that payment from my insurance company be made directly to FSMINJ or to the party who accepts assignment.
- I certify that the information I have reported with regard to my insurance coverage is correct. I agree and accept the terms of the FSMINJ Financial Policy.
- I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company any time in writing.

Signature (Patient/Guardian)____Date_____________