SouthernSpineSpecialists

Financial Policy for Patients

The patient is responsible for any and all account balances when Southern Spine Specialist or Patrick Curlee, MD does not participate in their insurance plan, there is not an insurance card on file, the patient has not met their deductible at time of service, or patients insurance deems services not medically necessary. Payment for the balance is expected monthly and must not exceed a 6 month period for pay off.

The patient will receive a statement every month and it is the patients' responsibility to stay on top of their insurance and make sure that their insurance is paying Southern Spine Specialists and Patrick M. Curlee, MD. All deductibles and co-pays are required at the time of service, unless previous financial arrangements have been made with the billing office (901) 818-2168. I also understand that *I am financially responsible for all charges for the services provided to me or my dependent by Southern Spine Specialists and Patrick M. Curlee, MD in which remain unpaid by insurance according to my coverage.*

My signature on this form authorizes Southern Spine Specialists and Patrick M. Curlee, MD to release information necessary from my file to secure payment of benefits from my insurance(s). Further, I hereby authorize the use of this signature as "Signature on File" for all insurance claim submissions in my behalf or my dependents behalf.

CERTIFICATE ASSIGNMENT AND RELEASE

It is MANDATORY by law that you inform us correctly regarding your insurance coverage. Section §1128B of the Social Security Act and 31 U.S.C. §§3801-3812 provide penalties for withholding or knowingly giving false information.

Self Pay Patients

I certify that I, myself, or my dependent registered hereon as the PATIENT, have no insurance coverage. I hereby assign any and all benefits payable for services rendered to me or my dependents by Southern Spine Specialists and Patrick M. Curlee, MD be paid directly to Southern Spine Specialists and Patrick M. Curlee, MD. I also understand that *I am financially responsible for all charges for the services provided to me or my dependent by Southern Spine Specialists and Patrick M. Curlee, MD.*

_☐_ I agree to pay my first visit in full on the day that services are provided.

_☐_ I agree to pay ½ of the required amount up front on following visits and make _____ monthly payments (not to exceed six months) of $ _____ until account balance is satisfied.

_☐_ I agree to make a payment of $ _____ every month on the _____ day until account balance is satisfied (not to exceed six months).

Patients Name _____

Signature _____ Date _____

**If patient is under 18 years of age, a Parent, Legal Guardian or person with Power of Attorney must sign for patient to receive medical care.*