

Summit Sports Medicine Authorizations/Payment Policies Chart# _____

This office is committed to providing patients with the best possible care.

AUTHORIZATION FOR SERVICES/RELEASE OF INFORMATION

The signature below serves as authorization for services rendered by J. Melvin Deese, Jr., M.D., Michael J. Sullivan, M.D., , Katherine Maurath, M.D., Denny A. Carter, M.D., Thomas M. Sasser, Jr., M.D., Ralph Cavalier, M.D., and Frank D. Clements, PA-C for the below named patient, and release of information necessary to file insurance and assign benefits otherwise payable to policy holder to the doctor or group indicated on the claim. This form also authorizes release of medical information for the purpose of patient referral, treatment of and or including treatment of workman’s compensation injuries. A copy of the signature is as valid as original.

NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided with the above practice’s Notice of Privacy Practices to review.

PAYMENT POLICIES

We need your assistance and understanding of our payment policy. **As a courtesy, Summit Sports Medicine will bill most insurances. HOWEVER, the patient is responsible for any non-covered or unpaid balances ***ALSO ANY REFERRAL NUMBERS OR AUTHORIZATIONS (EXAMPLE: TRICARE, Medicaid, Well care, PCN, ETC) NOT PROVIDED TO OUR OFFICE PRIOR TO APPOINTMENT*****

Your insurance coverage is a contract between you and your insurance company. All services are filed with your group insurance carrier providing you furnish all pertinent information to our office. **Insurance co-payments and deductibles are expected when the service is rendered**, which includes any Office visits, EMG’s, Injections or Surgeries. **We accept cash, personal checks, VISA and MasterCard.** You will continue to receive a statement each month even though your insurance is pending. **If you have surgery by one of our physicians you will receive more than one bill.**

For example: Office visits, X-rays, EMG’s, injections, and (Physician fees preformed either here or the Hospital), will be billed as a “Clinic account“. *****Note*** You will receive a separate bill for Operating Room/Hospital charges, anesthesiology services and lab work from outside of Summit Sports Medicine.**

(THE ABOVE PROVIDERS MAY NOT PARTICIPATE WITH YOUR INSURANCE COMPANY)

I have read the above **Payment Policy** and understand that even with insurance coverage, including controverted workmen’s compensation **if charges are denied I am financially responsible for my charges incurred.** **If I need to set up an extended payment arrangement,** I will contact the Patient Account Representative. **If no payment has been received after 90 days from the date of service, necessary collection procedures will begin.**

Or if, I am a private pay Patient:

I understand that I am being accepted as a private pay patient and I will be responsible for paying for all services rendered.

By signing this form, I acknowledge, I have read and understand all of the above Summit Sports Medicine’s policies and practices. and agree that all information provided by me is correct.

*****HIPAA CONTACT*****Name of person you wish to be given any billing and medical records information on your behalf:

Name: _____ Relationship to you _____

DOB _____ Social Security Number: _____

Home Phone: _____ Work# _____

Print Name _____ Signed: _____ Date: ____/____/____
(Patient) (Patient/Guardian)

*****Please request copy, if needed for your records*****