

South Bay Sports and Preventive Medicine Associates, Inc.

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San Jose, CA 95128
(408) 293-7767 Fax (408)294-6595

2039 Forest Avenue #204-A
San Jose, CA 95128
(408) 293-7767 Fax (408)271-9169

Patient Financial Responsibility Policy Notice

We would like to make the billing and payment process for services as simple as possible. Please read the following information regarding the financial policies of this office and initial the source of payment indicating how your services will be reimbursed.

_____ 1. **PRIVATE INSURANCE:** Professional services rendered to you (or your dependants) by South Bay Sports and Preventive Medicine Associates, Inc. (SBSPMA) are your sole financial responsibility. SBSPMA will bill your insurance as a courtesy, but you are ultimately responsible for payment for your treatment. You are financially responsible for any and all balances not paid by your insurance (i.e. deductible, co-pay, coinsurance, denied charges, and fees reduced by usual and customary charges). You are required to pay your reported co-payment on the day of your visit. Any other unpaid balance due will be reflected in your monthly billing statement. Please pay close attention to statements received from your insurance company as they may report balances due prior to receiving a statement from our office. Any unpaid charges on an account for 90 days are subject to collections action. **On occasion, an insurance company may send the check for services to you directly. If this occurs, you must reimburse the payment to our office by signing over the check.**

_____ 2. **WORKER'S COMPENSATION:** If you were injured during the course of your employment, please notify the front office so that you may complete the appropriate paperwork. Coverage will be verified with your employer and we will bill the worker's compensation carrier directly.

_____ 3. **MEDICARE:** If Medicare is your primary insurance, we will bill Medicare directly. There may be some expenses Medicare will not cover, and therefore you will be expected to sign a waiver and pay at time of service.

_____ 4. **CASH:** If you do not have insurance, you will be expected to pay for treatment at the time of service. The cost is \$75.00 for the first initial visit and \$90.00 per visit thereafter (this is a 50% discounted rate).

* Please direct any additional questions to the business office.
It is customary to pay for services at the time they are rendered. For your convenience, payments may be made by cash, check, Visa or Master Card.

I, THE UNDERSIGNED, HAVE READ THE ABOVE INFORMATION AND UNDERSTAND MY FINANCIAL OBLIGATION TO SOUTH BAY SPORTS AND PREVENTIVE MEDICINE ASSOCIATES, INC.

Patient (or Guardian) Signature

Date

Witness Signature

Date