ABQ Integrative Family Medicine

Experienced Concierge Care In Albuquerque

Financial Policy

Financial Responsibility
All professional services rendered are charged to the agreed-upon payer and are due at the time of service, unless other arrangements have been made in advance. Necessary forms will be completed to file for insurance carrier payments. All copay and payments are due at the time of service.

Assignment of Benefits
I hereby assign all medical, dental and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carriers, including Medicare, private insurance and any other health/ medical plan, to issue payment check(s) directly to **ABQ Integrative Family Medicine** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I may be responsible for any amount not covered by insurance. All copay and payments are due at the time of service.

Authorization to Release Information
I hereby authorize **ABQ Integrative Family Medicine** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from **ABQ Integrative Family Medicine** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately up presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

I understand that I will be responsible for any missed appointments or any cancelled appointments in which a 24 hour was not given. There will be a fee of $30.00.

I understand that there will be a $25.00 fee for all returned Checks.

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Print Name of Patient (or Responsible Party):

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Signature of Patient (or Responsible Party) Date:

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Only if needed:

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Guardian Signature: Relationship:

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Witness Name: Signature: Date:

04/2024