San Mateo Spine Center

SPINE & MUSCULOSKELETAL MEDICINE * PHYSICAL MEDICINE & REHABILITATION
334 N. San Mateo Dr. San Mateo CA 94401 - TEL 650-558-1802* FAX 650-558-1806

Financial Policy

We will gladly bill your insurance for services rendered at San Mateo Spine Center. We do this as a courtesy to our patients. However, to do so, we must have all insurance information provided to us before services rendered or payment in full is required. We will not become involved in disputes between you and your insurance company regarding eligibility, deductibles, co-payments, covered charges, or non-covered charges, etc., other than supply factual information to your insurance company as necessary. It is crucial you are aware of your insurance coverage benefits, such as consultation with Dr. Chen and medical procedures, such as injection coverage benefits, etc. If your services are denied due to being “non covered benefit", or "not a medical necessity", or lack of physical therapy", or "lack of objective findings", or "investigational” time restrictions, or "failure to get a referral" for your visit, you are responsible for the timely payment of services.

Name of Patient / Guardian:

Signature of Patient / Guardian: Date ______________________

Self-funding Payment Waiver

I wish to proceed with a self-funded medical evaluation and medical procedure today because I am in pain and I require immediate medical attention and I do not want to wait or delay my medical treatment due to any insurance issues, such as authorization issues, or non-covered issue. I acknowledge that I am not forced into self-funded medical treatment at San Mateo Spine Center; I am doing this willingly. I agree that this is a non-refundable payment and I will not demand a refund. I will handle this issue with my *o*wn insurances. I agree that San Mateo Spine Center will not become involved in disputes between me and my insurance company and I will not **dem**and San Mateo Spine Center for a refund due to lack of insurance coverage.

Name of Patient / Guardian:

Signature of Patient / Guardian: Date ______________________