JOSE VELIZ MD, JD
Diplomate of the American Board of Anesthesiology
Diplomate of the American Board of Pain Medicine
Fellow of Interventional Pain Practice

PALOMAR SPINE & PAIN

PATIENT REGISTRATION

Name _____ Birthdate_____ Age _____
Last First MI

Address _____ City _____ State _____ Zip _____

Checkmark preferred phone: [ ] Home Phone _____ [ ] Cell Phone _____

Sex [ ] M [ ] F Social Security # _____

Email Address _____ Employer _____

In case of Emergency notify _____ Relation _____ Phone _____

Circle one: PPO Medicare

Primary Health Insurance Carrier _____ Subscriber Name _____

Subscriber ID# _____ Subscriber Birthdate _____ Subscriber Social Security # _____

Insurance Carrier Phone # _____ Customer Service # _____

Secondary Insurance Carrier _____ Subscriber ID# _____

If it becomes necessary to contact you by phone, do we have permission to leave messages regarding medical care and/or appointments on your answering device, or with another person who answers the phone? [ ] Yes [ ] No
Please provide any instructions, if any, regarding the above question. (i.e., Do not leave messages with my husband Bob; Do not leave messages regarding medical care, but you may leave messages regarding appointments; etc.

Instructions: _____

_____

Records: We charge a standard $15.00 fee for all copied records.

After Hours: The after-hours phone number is for urgent matters that cannot wait until the following business day. It is not intended for emergency situations or routine care.

Referring Physician _____ **Primary Care Physician** _____

255 North Elm Street
Suite 101
Escondido, CA 92025
T 760.489.1876 F 760.489.1748

www.josevelizmd.com

FINANCIAL POLICY

Thank you for choosing us as your pain management provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this financial/payment policy. Please read it, ask any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Cash Patients**. If you do not have medical insurance payment in full is required at the time of service.

2. **Insurance.** Dr. Veliz is contracted with most insurance plans.

3. **Knowing your insurance benefits is your responsibility.** As a courtesy, we call your insurance company to verify benefits. However, we cannot be held responsible for a contract between you and your insurance company. Therefore, any financial quote given by our office is an estimate based on information provided by, or from previous dealings with, your insurance carrier. Please contact your insurance carrier with any questions regarding your coverage. Our staff will be happy to provide the information you need to check your own benefits.

4. **Co-payments and deductibles.** All co-payments, and if requested, partial deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company and failure to pay your co-pay violates that contract. Unless arrangements are set up prior to your visit, your appointment may be cancelled if you present without the required copay.

5. **Non-covered services.** Please be aware that insurance companies consider some treatments non-covered or not medically necessary. These services vary depending on the insurance carrier. You must pay the cash price for these services in full at the time of your visit. Our staff will be happy to provide you with any procedure code you need, so you may call your insurance carrier to confirm your treatment will not be covered.

6. **Proof of Insurance.** All patients must complete our patient registration forms before seeing the doctor. We must obtain a copy of your driver's license (or other accepted picture identification), and a current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, you may be responsible for the balance of a claim.

7. **Missed or broken appointments**. Appointments that are not cancelled 24 hours in advance are considered missed and a $25 dollar charge will be applied to your account.

8. **Change in coverage.** You are responsible for notifying our billing department of any coverage changes. If you fail to update us in a timely manner your claim may be denied for timely filing and you will be responsible for the balance.

9. **Claims submission.** We will submit your claims to your insurance company for you. However, our payment may be put on hold by your insurance company pending information they request from you directly. It is your responsibility to comply with their request in a timely manner. Failure to do so may result in the denial of your claim. You will be responsible for the balance of the claim if we are denied payment under these circumstances.

10. **Nonpayment.** Please be aware that if payment is not received 30 days after you are billed your account will be considered past due. If you cannot pay your balance in full, promptly call our billing department at (760) 489-1876 to inquire about setting up a payment plan. Please be aware that if a balance remains unpaid for 120 days, and we do not hear from you, your account may be referred to an outside collection agency and you may be discharged from the practice.

I have read and understand this financial policy, agree to abide by these guidelines and I give permission for Jose G. Veliz MD, Inc. to bill my insurance company.

Patient Printed Name	**Patient Signature**	**Date**

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