

Financial Policy

Facility Located at 1892 A Plaza del Sur

I fully understand that I am directly and completely responsible to my treating physician(s) for all medical bills submitted for goods and services provided to me, and this agreement is made solely for the additional protection of my treating physician(s). However, it is also understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated to me, my treating physician or its agents will refrain from attempts and efforts to collect the amounts owed directly from me. I also understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe to treating physician.

1. You are to release any information you deem appropriate concerning my health condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges to the physician by me.
2. I authorize and assign the direct payment any and all treating physician(s) or any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you in whole or in part upon the charges made for your services. If there is a requirement that the check be made directly to myself, I authorize that the physician(s) name be included on such check.
3. I give assignment and lien against any claims against a third party whose negligence I have caused my injury, up to the amount of the bill for treatment. This includes but is not limited to so called Tort or third party auto insurance claims.
4. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refused to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit
5. Limited Power of Attorney: I hereby grant to the treating Physician/facility power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company for payment of treatment and health care rendered by physician/facility. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.
6. I further agree to and do hereby irrevocably waive any right I have or may have, whether arising pursuant to the decision in Martinez vs. St. Joseph Health Care System, 117 N.M. 357 (1994) or otherwise require treating physician to reduce the payment on the bills by a proportionate share of the attorney fees, costs and other expenses of pursuing collection of my claims arising from this accident, I understand that the law may allow me to pay less than the full amount of my billing to treating physician, but I give up this right in return for the aforesaid consideration provided by treating physician/facility.
7. I waive the Statute of Limitations regarding my physician's right to recover.

Signed: _____ Date: _____

Witness: _____ Date: _____

A photocopy of this instrument shall serve as original.