MIDESSA
NEUROSURGERY & COMPLEX SPINE
Texas neurosurgery and spine destination

8050 E. HWY 191
Suite 250
Odessa Texas 79765

(432) 558-7000
(432) 214-2400
midessaneurosurgery.com

PATIENT FINANCIAL RESPONSIBILITY CONTRACT

This is a legally binding contract between Midessa Neurosurgery and Complex Spine and you. The words, I, me, my, you and your all refer to the patient. The words we refer to Midessa Neurosurgery and Complex Spine.

I agree to be financially responsible for payment of Midessa Neurosurgery and Complex Spine services. Cash, check or credit cards are acceptable forms of payment for these services.

Initial:_____

Current insurance cards must be presented at every office visit. We are not responsible for filing your insurance claim, but as a courtesy we will do so. I agree to pay any remaining balance after my insurance has paid on my claim immediately upon receipt of a statement.

Initial:_____

I agree to give Midessa Neurosurgery and Complex Spine my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment. I agree to pay Midessa Neurosurgery and Complex Spine the balance on my account after insurance claim has been processed.

Initial:_____

I agree that if my insurance benefit requires a referral and the referral is not in place before my appointment, that I will pay in advance an estimate of charges or reschedule my appointment.

Initial:_____

I understand that I will be responsible for any missed appointments or any cancelled appointments in which a 48-hour notice was not given. There is a $25.00 fee for any missed office visits.

Initial:_____

I understand there will be a $35.00 fee for all returned Checks.

Initial:_____

I understand that my insurance may or may not agree to the usual, customary or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been approved of in advance. I agree to pay the balance remaining on my account after insurance has been processed.

Initial:_____

If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

Initial:_____

I agree to pay co-payments and deductibles at the time of service. If co-payments are not made at the time of service, I understand that my appointment may be rescheduled.

Initial:_____

If my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

Initial:_____

I have received, read and understand Midessa Neurosurgery and Complex Spine patient Financial policy and agree to it.

Initial:_____

I have read and I understand Midessa Neurosurgery and Complex Spine financial policies and I accept responsibility for the payment of any fees associated with my care.

Signature of Patient / Representative

Patient Name

Date