INSURANCE INFORMATION & STATEMENT OF FINANCIAL RESPONSIBILITY

1. I authorize release of any information necessary to process my insurance claims and assign and request payment directly to SVT Health & Wellness (SVTHW). I understand that SVTHW will bill my insurance as a service to me; however, I am ultimately responsible for co-payments, deductible payments, and all charges for services not covered by my insurance plan at the time of service

Please Complete - Primary Insurance	Please Complete - Secondary Insurance
Insurance Company Name:	Insurance Company Name:
ID:	ID:
Group/Policy #:	Group/Policy #:
Subscriber's Name:	Subscriber's Name:
Subscriber's Phone #:	Subscriber's Phone #:
Subscriber's Employer:	Subscriber's Employer:
Subscriber's SS#:	Subscriber's SS#:
Subscriber's Date of Birth:	Subscriber's Date of Birth:

2. I understand that I may revoke this consent at any time in writing to the office.

3. If being seen for a **work-related injury** involving Workman's Compensation**,** please provide the name of the insurance carrier to be billed for your care:

Insurance Carrier Name:	
Phone Number:	

4. I agree that I am responsible for payment of all products or services rendered to me, or the patient for which I am the guarantor of payment, in accordance with the regular rates and terms of SVTHW.

5. I understand that SVTHW will make all reasonable attempts to collect amounts due and failure to adhere to payment agreements or financial responsibility may result in:
   a. My account being sent to a collections agency or attorney, with applicable fees (including attorney's fees and/or collections expense) assessed. All delinquent accounts may bear interest at the legal rate.
   b. Full payment will be expected prior to all future visits.
   c. Denial of non-emergent appointments.

6. Should I qualify for American Indian/Alaskan Native beneficiary benefits, I understand that the Indian Health Service (IHS):
   a. is the payer of last resort. All other insurance (Medicare, Medicaid, private insurance) must be billed first.
   b. will NOT pay for office visits/labs/dental/radiology services at another facility without a referral from an SVTHW provider before the services are performed, unless it is a life-or-limb emergency.
   c. requires that I present a copy of my Tribal Enrollment card, copy of my Certificate of Indian Blood/BIA Card, Photo ID (driver's license or passport), income and household information, and for infants a copy of Birth Certificate (if available).
   d. I will be contacted annually to update this information.

7. I have read the above information and have no further questions. The income and household information provided by me is true to the best of my knowledge. Should I qualify for a Sliding Fee Discount, I understand that I will be asked to update my income and household information at least annually, and may be subject to proof of documentation requests.

Signature **Print Name** **Date**
If not signed by Patient:

Guarantor's Relationship to Patient **Guarantor's SSN** **Guarantor's DOB**