

Southwest Advanced Neurological Rehabilitation, dba
SWAN Rehab, LLC

Payment Policy

Welcome to SWAN Rehab! Please choose one of the means of payments described below, by checking the appropriate box.

_____ Self-Pay – If you are paying for treatment without insurance, you agree to pay for all charges incurred at the time of service. In the event you are unable to pay the balance in full, advise us prior to the time of service, and we will discuss a payment plan. We are not a credit grantor, and therefore, failure to maintain these agreements may result in the placement of your account with an agency or attorney for collection.

_____ Primary Insurance – As a service to you, we will file your claim with your primary insurance company if you provide us with current insurance information. However, any charges not paid by insurance will be the responsibility of the patient, legal guardian or admitting parent. All co-pays are due at the time of service.

YOU MUST NOTIFY US PRIOR TO ANY CHANGES TO YOUR INSURANCE COVERAGE AND PROVIDE US WITH INFORMATION RELATING TO YOUR NEW INSURANCE COMPANY. IF ANY CHARGES ARE DENIED BY YOUR NEW INSURANCE, YOU WILL BE RESPONSIBLE FOR THE CHARGES NOT PAID BY INSURANCE.

ALL SUPPLIES ARE PAYABLE AT THE TIME OF SERVICE. WE WILL FILE FOR ANY COVERED SUPPLIES ALLOWED BY YOUR INSURANCE CARRIER.

Please be aware that you will remain financially responsible for any and all services and supplies received regardless of the payment option selected above. In the event your account becomes delinquent and is therefore in default of payment, the patient, legal guardian, or admitting parent will be responsible for the principle amount owed and all reasonable costs associated with the collection of this debt, including, but not limited to, collection service fees, attorney's fees, all court costs, and additional legal expenses associated with recovery of the debt.

Payment is due in full 30 days after the date of the invoice. If we receive payment within 20 days from the date of the invoice, we will provide you a 3% discount.

Thank you for allowing us the opportunity to service you. Please sign and date this form. If you have any questions, please ask for our assistance.

Signature _____ Date _____

Relationship to patient: _____