Financial Policy/Assignment of Benefits

My Insurance Company: _____.

"I AUTHORIZE, REQUEST, AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO OM MEDICAL GROUP, PC, ANY AND ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the release of any information necessary to my insurance company, including but not limited to diagnoses, test results, and treatment notes in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions. I understand all payments not covered by insurance are due at the time of service and failure to pay may result in not being able to see the provider."

PRINT NAME_____SIGNATURE: _____ DATE: ___/___/___

This clinic participates with many different insurance companies. Please keep in mind that your insurance policy is a contract only between you and that company. There are many different agreements for covered services between different insurance companies and it is not possible for this clinic to know which services are covered in advance. We encourage all patients to contact their insurance company if they have any concerns over covered services. We are happy to submit claims to your insurance on your behalf but ultimately you will be responsible for any services not covered.

Payment for any co-pays, deductibles, or noncovered services are expected at the time of service. Payment for amounts not covered by your insurance company are due within 30 days of receiving a bill. We accept cash, check, Visa, Master Card, Discover, and American Express.

It is the patient's responsibility to always provide accurate, up-to-date information concerning any changes to primary and secondary insurance benefits. It is also the patient's responsibility to notify the clinic regarding any open medical/legal claims such as Workers Compensation or Personal Injury/Motor Vehicle Accidents.

We recommend patients contact their insurance company to find out if services provided outside of this clinic such as laboratory, diagnostics, or specialist visits are covered before scheduling the services.

- Administrative Fees:
  - Prior Authorizations $10
  - Miscellaneous Paperwork (FMLA, Disability, Social Security, etc) $25
  - Returned Check/Non-Sufficient Funds $35
  - "No Show" $60
    - *(A minimum of 25 minutes of face-to-face time have been blocked-out with your provider as a unique added benefit to our patients. As such, patients needing to cancel or reschedule must do so greater than 24 hours before scheduled appointment.)*

"By signing below, I attest that I am in receipt of and understand the above financial policy. I also understand that if I have any questions or concerns, I can address these with clinic staff."

SIGNATURE: _____ DATE: ___/___/___