# PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Optimal Health & Wellness (OHW) as your health care provider. We are honored by your choice and are committed to providing you with the highest quality health care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Initial _____ The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his or her own treatment and care. Payment is due at the time services are rendered.

Initial _____ Delinquent account may be turned over to a collection agency. Additional expenses incurred while collecting a delinquent account are patient's responsibility.

Initial _____ Other charges (but are not limited to) include: $12 returned check fee, extensive completion form, extensive records requests and etc.

Initial _____ If your insurance has qualifying coverage for our services (verified by OHW), we will bill your insurance as an out-of-network provider. **You are responsible for the payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by your insurance plan.** You are required to provide us with the correct and the most updated insurance information and will be responsible for any charges incurred if the information provided is not correct or updated.

Initial _____ **If insurance reimbursement checks for services provided by OHW are sent to you directly, it is your responsibility to include the Explanation of Benefits (EOB) with the reimbursement to our office within 30 days of receipt.** Failure to do so may result in patient being billed for services rendered.

Initial _____ **Cancellation of appointments with less than 24 hours notice and missed appointments will be subjected to a charge of $25 fee. No Insurance can be billed for missed appointment.**

Initial _____ While we make every effort to work with you, sometimes it is best for all parties involved to part company. Reasons for dismissal may include: failure to keep appointments, noncompliance, abuse of staff, and non-payment.

I hereby acknowledge that I have read, understand and accept the financial responsibility at Optimal Health & Wellness:

______________________________________________________________

Signature of Patient or Guardian Date

***Patient Authorizations***

- By my signature below, I hereby authorize OHW and the physicians, staff, and hospitals associated with OHW to release medical and other information acquired in the course of my examination and/or treatment(with the exceptions stipulated below) to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.
- By my signature below, I hereby authorize assignment of financial benefits directly to OHW and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize OHW personnel to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.