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WOMEN'S HEALTH

FINANCIAL RESPONSABILITY

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business management. Necessary forms will be completed to file for insurance carrier payments.

Please select one of the following payment options:

Assignment of Benefits - **Insurance**

☐ I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), private insurance and any other health/medical plan to issue payment check(s) directly to Monterey OBGYN Medical Group.

Insurance Waiver and Payment Agreement-**Self Pay**

☐ I have chosen to be self-pay for health care services provided by Monterey OBGYN Medical Group. I have decided to be self-pay even though I may have health insurance that covers these services and waive my right to have a claim submitted to my insurance company on my behalf. **I agree to pay for services in the office on the date they are performed**.

Authorization to Release Information:

☐ I hereby authorize Monterey OBGYN Medical to: (1) release any information necessary to insurance carriers regarding my illness and treatments: (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

☐ I have requested medical services from Monterey OBGYN Medical Group on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

☐ I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

OFFICE CHARGES

There is a $50.00 fee for no show on late cancelation of appointment. A 24-hour notice is required to avoid changes.
There is a $25.00 charge for each check returned to us for non-sufficient funds.
There is a $30.00 charge per form to be completed. (Applies for some forms only)

_____ _____

Patient or Responsible party (Print Name) Date

_____

Signature

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