LAiMA OB/GYN Medical Group

337 Eldorado Street #B4, Monterey, CA 93940

Phone- 831-373-2486, Fax- 831-373-6519

Financial Policy and Consent to Treat

Please, review carefully before signing.

LAiMA OBGYN Medical Group participates in multiple insurance plans and offers care-credit payment options. Additionally, we understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such issues with our billing service for assistance.

1. I understand that I am personally financially responsible for my bill and all charges related to my care are **my financial responsibility.**

2. If my insurance denies payment for service or procedure performed by LAiMA OB/GYN as a "non-covered" benefit under my plan (Medicare/Commercial Insurance), these charges become my financial responsibility.

3. I understand that I am responsible to be familiar with the specifics of my insurance coverage, expected deductibles, and covered and non-covered services.

4. I accept that it is my responsibility to make prior arrangements to cover deductibles or have sufficient funds to cover my medical costs. I understand that I am **expected to pay fees for service and unpaid deductibles, co-payments, administrative fees at the time of service.**

5. I understand that I may not be able to see a clinician if I have an outstanding balance and no prior arrangements have been made. In case of a life-threatening medical emergency, my care will be referred to the nearest emergency department.

6. I understand that if my insurance company does not pay my balance in full within 30 days, it is my responsibility to contact my insurance and provide all necessary information.

7. I understand that my unpaid balance will be subject to collections via small claim court with possible applicable attorney/collections fees.

Signed_____ Date_____

CONTINUED:

Authorization To Release and Assign Insurance Benefits

I authorize release of any information required to act on any insurance claim and hereby assign LAiMA OB/GYN, INC the medical and surgical benefits I am entitled to from my insurance company or Medicare. This authorization is in effect of all future claims, until I choose to revoke it in writing. I, the undersigned, understand and agree to the above financial policy and consent to Treatment. I understand that I am financially responsible for all charges incurred for my medical treatment.

Signed_____ Date_____