Patient Financial Consent Form

Copayment/Deductible and Co-insurance are due on the day of services; Forms of payment accepted: Cash, Check, MasterCard, Visa, American Express or Discover.

Dr. David Ochoa will submit insurance claims for you. However, if the service is not covered under your policy, you are responsible for the balance due. Bear in mind that you are responsible to know and understand your insurance policy and are ultimately responsible to pay Dr. David Ochoa for your entire account balance regardless of your insurance company's payment schedule.

Consent to Release Information*

☐ I hereby give my consent to Dr. David Ochoa to release any information regarding my care and treatment as may be required by my insurer. I authorize the release of any medical documentation to insurance companies and medical providers as necessary.

Additional Fees:

Cancellation Policy/Fees: If I am unable to keep an appointment, I will notify Dr. David Ochoa office no later than 24 hours prior to an Office Visit. If I fail to provide proper notification I will be charged accordingly:

• No Show Fee	$25.00
• Non-Sufficient Funds (NSF) Banks Fee:	$35.00
• *Wellness Forms	$15.00
• Letter, Forms, Correspondence,etc.	$25.00
• FMLA (New or Revisions)	$35.00
• Short Term or Long Term Disability Forms, etc.	$35.00
• Copy of Lab Report (mailed)	$ 2.50
• Medical Records (Contact our office)	

ABOVE FEES ARE NOT BILLABLE TO INSURANCE

Assignment of Benefits*

☐ I hereby authorize payment to be rendered directly to Dr. David Ochoa for the benefits otherwise payable to me by any third party. The above authorizations are in effect permanently or until canceled by myself in writing.

If your insurance company rejects a claim because a valid authorization or referral was not in place, the full cost of the visit will be your responsibility. I have read this policy and understand that delinquent accounts may be assigned to a credit reporting and collection service after **60 days** of receiving the billing statement unless other arrangements have been made.

Patient Name* (Print)

First:_____Initial:_____

Last Name:_____

Date of Birth* _____

PATIENT'S SIGNATURE:*_____

Date:_____

Office Use Only:

Verified:_____Date:_____