



U WELLNESS  
SURGICAL

## FINANCIAL POLICY

1. A copy of your photo ID and insurance card is requested upon check-in.
2. Copayments and balances are due at the time of service.
3. Procedures done in the office including Anoscope's may be subject to annual deductible and will be billed separately once the claim is processed.
4. This office accepts credit cards (VISA/MASTERCARD AND DISCOVER).
5. This office accepts checks with the proper identification.
6. There will be a fee of **\$25.00** for returned checks.
7. A 24-hour notice is required to cancel office appointments or there will be a fee of **\$50.00** charged to you. This charge is not billed to your insurance.
8. A 72-hour (business hours) notice is required to cancel/reschedule any surgery or procedure to be done in the hospital/ surgery center or there will be a fee of **\$200.00** charged to you.
9. There is a fee of **\$25.00** for the completion of forms such as EDD (state disability), FMLA, etc.
10. Any bills or balances are due within 30 days of final payment by the insurance company.
11. Supplemental/ secondary insurance claims will be filed when appropriate.
12. For large balances payment arrangements can be made.
13. If you do not have insurance (CASH PAY PATIENTS) total payment is due at time of service.
14. Changes to insurance, home address, or phone number should be reported immediately to the office for billing and other purposes.
15. Telephone number to call with account questions is **925-430-5613**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## ASSIGNMENT OF BENEFITS

I, the responsible party certifies that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays In insurance payment or denial of insurance coverage.

It is my responsibility to understand and have personally verified if my insurance is contracted with this practice and/or the doctor I am seeing.

I hereby authorize U Wellness Surgical to apply for benefits and receive payments directly on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering services for the purpose of satisfying charges billed.

I further agree to pay all collection costs, attorney fees and any other collection costs that may be incurred in the attempt to collect outstanding patient responsibility amounts.

I also understand that if any insurance payments are sent directly to me, it is my responsibility to send these monies directly to U Wellness Surgical. immediately upon receipt.

I, the patient or the patient's representative, understand that all medical doctors at U Wellness Surgical are licensed and regulated by the Medical Board of California.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## ASSIGNMENT OF BENEFITS

I hereby authorize U Wellness Surgical to apply for benefits and receive payments on my behalf for covered services rendered. I agree that I am financially responsible to U Wellness Surgical for charges not paid under my insurance policy. I agree that a photocopy of this form may be used in lieu of the original.

### **Release of Information:**

I hereby authorize U Wellness Surgical to disclose all parts of my clinical records to any insurance company covering services for the purpose of satisfying charges billed.

### **Medicare Patients:**

I request that payments of authorized Medicare benefits be made payable to U Wellness Surgical on my behalf on any services furnished to me. I authorize any holder of medical information to release to the Health Care Financing Administration and its agent any information needed to determine benefits of the payable of related services.

I understand that my signature request that payment be made and authorizes the release of medical information necessary to pay claims. My signature authorizes the release of information to the insurance agency covering services provided by U Wellness Surgical. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as a full coverage, and I am responsible only for deductible, co-insurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

**THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND DOES UNDERSTAND THE ABOVE TERMS AND CONDITIONS.**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## OPEN PAYMENTS DATABASE NOTICE

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at [openpaymentsdata.cms.gov](http://openpaymentsdata.cms.gov)

The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals.

My signature below confirms that I have read and understand that notice above.

Patient Name: \_\_\_\_\_

Patient Representative Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_