Medical Office Financial Agreement

Patient Name:_____ **DOB**:_____

Financial Responsibility and Policy Agreement

Thank you for choosing Okerblom, Voegele, and Hole MD. We are committed to providing you with the best possible care. Please understand that payment of your bill is considered part of your treatment.

1. **Patient Responsibility:** I understand that I am ultimately responsible for all fees and charges for services rendered to me or the patient named above, regardless of insurance coverage.
2. **Insurance Coverage:** As a courtesy, Okerblom, Voegele, and Hole MD will submit claims to my insurance company. I authorize the release of medical information necessary to process these claims.
3. **Co-pays and Deductibles:** All co-payments, deductibles, and co-insurance are due at the time of service.
4. **Non-Covered Services:** I agree to pay for any services that are determined by my insurance plan to be not medically necessary or otherwise not covered.
5. **Payment Terms:** If a balance is due, a statement will be sent to you. Unpaid balances over 120 days may be subject to collection actions.
6. **Returned Checks:** A fee of $25.00 will be charged for any returned checks.

A holder of this medical debt contract is prohibited by section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

I have read, understand, and agree to the provisions of this Financial Policy.

_____ _____

Signature of Patient/Guarantor **Date**

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Printed Name