FINANCIAL & BILLING AUTHORIZATION
(Please Initial & Sign)

____ I request billing & payment of authorized insurance benefits be made on my behalf to Johnson Osteopathy & Medical Acupuncture (JOMA) for any services provided to me by JOMA now or in the future.

____ I understand that insurance companies do not provide JOMA with a list of diagnosis codes that it covers and that JOMA has no knowledge of what my insurance will or will not cover.

____ I understand & agree that it is my responsibility to inquire to my insurance carrier about coverage for all services/charges and understand my policy coverage to the best of my ability.

____ I understand that if my insurance company declines payment for any services including, but not limited to those deemed "experimental" or does not provide coverage for this service for my condition or diagnosis deemed not a "medical necessity" for Osteopathic, Acupuncture, Testing or other services obtained/ordered through this office that I will be responsible for any and all charges incurred.

____ I understand that although my insurance policy states that it will cover a certain number of office visits, acupuncture or osteopathic manipulations that it may not cover these for my diagnosis, symptoms, or the length of time of an extended office visit.

____ I understand & agree that I am financially responsible for the services provided to me by JOMA, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance.

____ I understand & agree that JOMA is not responsible for any charges/bills incurred by me as a result of consults or testing ordered by or incurred through referrals from this office to any other party.

____ I agree to immediately remit to JOMA any payments that I receive directly from insurance or any source whatsoever for the services provided to me, and I assign all rights to such payments to JOMA.

____ I authorize JOMA to appeal payment denials or other adverse decisions on my behalf without further authorization.

____ I authorize and direct any holder of medical information or documentation about me to release such information to JOMA and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by JOMA, now or in the future.

____ I understand & agree that if JOMA does not accept my insurance that full payment is due at the time of service.

____ I understand that all copays are due at the time of service. If I do not have a check or a valid credit card for my copay, I understand that I will be billed for this amount.

____ I understand that if I do not agree with the above policies or treatment plans that I have the right to decline treatment and/or seek treatment from other providers.

(CONTINUED ON NEXT PAGE)

___ Co-Pays
I am required to pay your co-payment in full at the time of service. We accept check and credit cards. (There will be a $25 charge for any returned checks with insufficient funds). We do not accept cash.

___ Missed Appointments/No Shows
In an effort to help as many patients as possible, it is important that I keep appointments or call to let the office know I cannot keep the appointment. Missed appointments are those that are cancelled with less than 24 hours notice. There will be a $50 charge for missed appointments and a $100 charge for "no shows"(appointments that were not cancelled by the patient did not show up for the appointment). We understand that late cancellations are sometimes unavoidable and consideration will be given in such situations. Please contact us as soon as you know you will not be keeping your appointment.

___Collections Activity
Patients will be dismissed from the practice if any collection agency involvement is required to collect on their account. This will adversely affect my credit. Patients will not be allowed back into the practice if they have been dismissed. **I understand any cost incurred through collections will be my responsibility—not JOMA**.

___ New Patient Booking Fee
I understand that a $150 dollar booking fee is non-refundable in order to reserve my appointment as a new patient. I also understand that this deposit will go to the time of service when I arrive at the appointment. If patient cancels within 48 hours from time of their appointment, the deposit then becomes refundable.

___Late Payments
I am responsible for charges/billings that your insurance company does not cover after all adjustments have been applied. I am expected to pay these bills within 30 days of receipt. There will be a $10 charge applied to your account for every subsequent billing required. In addition, any past due balance must be paid in full prior to making any further appointments. If you are having difficulty making the payment in full, please contact us, and we will setup a payment plan.

The patient must sign here unless the patient is a minor or physically or mentally incapable of signing. By signing here, I acknowledge and agree to all of the above.

Patient Signature or Mark:_____Date: _____

If patient is physically or mentally incapable of signing or under 18 years of age then please complete below:
□ Patient's Legal Guardian* □ Patient's Health Care Power of Attorney
I am signing on behalf of the patient. I recognize that signing on behalf of the patient is acceptance of financial responsibility for the services rendered.

Parent/ Guarantor _____ Date: _____

Relationship to Patient: _____

*Parent/Guarantor DOB: _____ Parent/Guarantor SSN: _____

Legal Guarantor's Address: _____
(if different than patients): _____
Phone # _____