OCEAN MEDICINE

4902 Irvine Center Drive, Suite 104, Irvine, CA 92604
Phone: (949) 446-8990 Fax: (949) 446-8535

AASM ACCREDITED Facility Member™

STATEMENT OF FINANCIAL RESPONSIBILITY

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Ocean Medicine participates with most major health plans and accepts payment directly from them. As a courtesy to patients, we send claims to primary, and secondary carriers. However, it is important to understand that your insurance policy and benefits are an arrangement (contract) between you and your insurance company. You are personally responsible for all Copays, a Co-Ins (percentage), or a Deductible. Certain insurance plans will authorize a specific number of visits for a certain period of time. Please be sure that you are aware of these details, as you will be personally liable for any visits that fall outside of that scope, and are denied by your plan. When in doubt, please verify this information with your insurance company. Our staff will do their best to verify insurance eligibility and benefits, but ultimately it is the patient's responsibility to know their policy and coverage. Please be aware that if you are not the Subscriber on the insurance policy you present, there will be documentation that is sent to the Subscriber regarding claims made against this policy. All patients that present without valid insurance information will be considered a Self-Pay Patient, and will be required to pay at the time service is rendered, unless prior arrangements have been made.

Credit Card Authorization Form

Credit Card Number	Expiration Date	CVV

Name on Card	Billing Address

I, ____, authorize Ocean Medicine to charge the above referenced credit card for **missed or canceled appointments** without 24 hours of notice, as well as Copays Deductibles and Coinsurances for services that are **not covered by my insurance policy**.

I have read and understand the financial responsibility agreement. By signing below, I acknowledge that in order to make appointments I must have a form of payment on file.

Patient Printed Name	Patient Signature, if of legal age.	Date
Parent/Guardian Printed Name	Parent/Guardian Signature	