FINANCIAL POLICY

Thank you for choosing OSMC as your health care provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered part of your treatment. The following statement explains our **Financial Policy** which we ask you to read, sign and return to us prior to your treatment.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
- All applicable co-pays, personal balances, both current and prior, are due at time of service.
- We accept cash, check or VISA, MasterCard, and Discover credit cards.

REGARDING INSURANCE:
We participate in many insurance plans and networks. It is the patient's responsibility to determine if the physician they are seeking services with, participates in their health insurance plan or network. For some insurance we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance plans.

USUAL AND CUSTOMARY RATES (UCR):
We are committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region and specialties. If your insurance company uses a different fee schedule, you will be responsible for any balance remaining.

RETURNED CHECKS:
For checks returned to us as unpaid by your bank, we will charge a $30.00 fee.

MINOR PATIENTS:
The adult accompanying a minor and the parents (or guardians) are responsible for full payment. For unaccompanied minors we will provide only emergency care unless other arrangements have been made prior to the service.

I have read the Financial Policy. I understand and agree to the Financial Policy.

_____ _____

Signature of patient or legal representative Date

I authorize release of medical information to my insurance carriers for services rendered by the providers of OSMC and all affiliated corporations. In addition, I also authorize the release of payment information from my insurance carriers to OSMC and all affiliated corporations. In addition, I request payment(s) of authorized benefits be made directly to OSMC and all affiliated corporations. I understand I am responsible to pay all non-covered services.

I authorize treatment by the attending physician.

_____ _____

Signature of patient or legal representative Date

2310 California Road
Elkhart, IN 46514
574-264-0791
www.osmc-online.com

WELCOME TO OUR OFFICE
PLEASE TELL US ABOUT YOURSELF

Patient Information (please print)

Patient Name (Last) (First) (M) Sex Birthdate Age Social Security Number

Street Address

Marital Status: ____ Married ____ Single ____ Widowed ____ Divorced ____ Separated

City State Zip

Home Telephone: ( ) _____ **Cell Phone:** ( ) _____

Work Telephone: ( ) _____ **Employer Name:** _____

Referring Doctor: _____ **Family Doctor:** _____

Person to Contact in Case of Emergency: _____ **Phone:** ( )_____

Spouse/Parent Name: _____ **Spouse/Parent Birthdate:** _____ **SSN:** _____

Spouse's Occupation & Employer: _____ **Work Phone:** ( ) _____

BRIEF DESCRIPTION OF INJURY / ACCIDENT / SYMPTOMS AND HOW IT OCCURRED

When did it occur? _____

Location of Accident/Injury? Home: _____ **Work:** _____ **Autmobile:** _____ **Other:** _____

If this accident or injury occurred at work, are you eligible for Worker's Compensation? _____ **Yes** _____ **No**

BILLING INFORMATION – PERSON RESPONSIBLE FOR FINANCES

If child or other than patient, who is responsible for the bill?

Name: _____
(Last) (First) (M) Social Security Number

Address: _____
City State Zip

Employer: _____ **Work Phone:** ( ) _____

INSURANCE INFORMATION

Name of Insured Birthdate Insurance Company Name Address ID or SSN Account/Plan #

1ST Health Carrier: _____

2nd Health Carrier: _____

3rd Health Carrier: _____

PLEASE COMPLETE OTHER SIDE