Print Patient Name	Date of Birth	Print Name of Legal Representative and Relationship to Patient

PATIENT FINANCIAL AGREEMENT

Initials _____ 1. **Missed Appointments:** Please help us serve you better by keeping your scheduled appointments. Cancel or reschedule appointments 48 hours prior to your scheduled appointment time. A $50.00 cancellation fee will apply for missed appointments for existing patients and $75 for new patients if notice is not received by 12:00 P.M (noon) the prior business day. These charges will be your responsibility and billed directly to you.

Initials _____ 2. **Deductible/Co-Insurance:** Please bring your insurance card(s) to all appointments. All applicable co-insurance and deductibles are due at the time of service. An estimate will be provided and payment is required before services are rendered. This does not constitute final payment and any additional balance due after the insurance claim is adjudicated will be due upon receipt of a bill.

Initials _____ 3. **Co-Payments:** Your insurance company requires us to collect co-payments at the time of service. Due to state and federal laws, co-payments will not be waived.
Checks: Returned checks may be subject to a $30.00 fee.

Initials _____ 4. **Cash Pay Patients:** The amounts you pay for today's scheduled office visit may not be your final payment. Other costs that may be accrued for today's appointment include, but are not limited to, tests, any injections, special procedures, or additional office visit charges.

Initials _____ 5. **Claims Submission:** As a courtesy, DR. PM Corp. will bill your insurance. A quote of benefits is not a guarantee of payment. We will submit your claims and assist you until claim is resolved. Payment from your insurance company is expected within 45 days. After 45 days, we will look to you for full payment. You are responsible for all non-covered services according to your insurance company's guidelines. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred and payment is due upon receipt of the bill. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request in a timely manner. You are responsible to provide a copy of your most recent insurance cards for all applicable health plans. Accounts that are 90 days past due may be referred to a collection agency.

Initials _____ 6. **Assignment of Benefits and Financial Agreement:** In order to serve you more efficiently and to minimize the chance of any further misunderstanding, please read the following: I hereby give authorization for payment of insurance benefits to be made directly to DR. PM Corp., a California Corporation. I understand that I am financially responsible for all charges, whether or not they are covered by insurance, and I may be charged a fee for missed or canceled appointments if I do not give one business day's notice. I hereby authorize this healthcare provider to release all information, including psychiatric and chemical dependency, history to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I understand that I am also responsible for advising DR. PM Corp. of any changes to my insurance, address, and phone numbers on or before the service date. If my insurance does not cover any office visit, any diagnostic testing, and/or treatment, I understand that I am responsible for full payment of services rendered and will make prompt, satisfactory arrangements to settle my account. I certify that I have read and understand the above assignment of benefits and financial agreement.

If at any time you should experience financial hardship and need to make special payment plan arrangements, please contact us.

I agree to comply with the financial policies of Dr. PM Corp., and I understand that I am financially responsible for payment of all medical services or treatment(s) administered with my account.

Patient (or Legal Representative) Signature	Date

INFORMED CONSENT FOR TELEHEALTH

1. I understand that my healthcare provider wishes to evaluate, diagnose, manage, and/or treat my medical condition through an interactive video communication involving the electronic transmission of information referred to as "telehealth" or "telemedicine." I further understand that because my provider and I are not in the same room, a telehealth consultation will not be the same as an in-person visit as my provider must rely solely on the information reported to make recommendations.
2. I understand that while steps are taken to secure telehealth communication, there is no guarantee of security, and there are potential risks to this technology, including interruptions and disconnections of the audio/video link, unauthorized access, and other technical difficulties.
3. I understand that my healthcare provider or I can discontinue the consultation at any time for any reason. I further understand that I can be seen in person at another time and confirm that my participation in telehealth is completely voluntary.
4. I understand that while this telehealth session will not be recorded, it will be documented.
5. By participating in a telehealth consultation, I confirm that the risks, benefits and any practical alternatives have been discussed, I have had the opportunity to ask questions regarding the process, and that my questions have been answered to my satisfaction.
6. I am aware that I am responsible for any portion not covered by insurance per the Assignment of Benefits and Financial Agreement.

Patient (or Legal Representative) Signature _____ Date _____

ACKNOWLEDGMENT OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, available online, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Patient (or Legal Representative) Signature _____ Date _____

AUTHORIZATION TO COMMUNICATE WITH SOMEONE OTHER THAN YOURSELF

I, the patient or the patient's legal representative, hereby authorize Dr. PM Sleep and Wellness Medical Center to communicate with the person(s) listed below about my protected health information on my behalf.

Print Name _____ Relationship _____

Print Name _____ Relationship _____

Patient (or Legal Representative) Signature _____ Date _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This authorization becomes effective upon signing and will expire upon my written revocation.

I, the patient or the patient's legal representative (named below), hereby authorize Dr. PM Sleep and Wellness Medical Center to receive my medical records as needed for medical evaluation.

In addition, I authorize Dr. PM Sleep and Wellness Medical Center to release my medical records, to the extent necessary, to a healthcare entity involved in my treatment.

A healthcare entity may include another physician whom I am seeing regarding my health or a company that provides appropriate medical treatment devices.

Print Patient's Name	Date of Birth
Patient (or Legal Representative) Signature	Date
Print Name of Legal Representative and Relationship to Patient	