Patient Label

DESERT OASIS HEALTHCARE

Your Health. Your Life. Our Passion.

PATIENT ACKNOWLEDGEMENT SHEET

Please initial next to each item signifying your acceptance, then sign and date the form at the bottom of the next page. Thank you.

AUTHORIZATION TO PAY PHYSICIAN:

_____ I authorize my Insurance Company(ies) to pay by check made out and mailed to Desert Oasis Health Care (DOHC), Inc., 275 N. El Cielo, Ste C, Palm Springs, CA 92262 (if my current policy prohibits direct payment to doctor, then I also authorize the check be made out to me and mailed to the above address), for any and all expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This payment will not exceed my indebtedness to DOHC, and I have agreed to pay in a timely manner, any balance that are over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

ABOUT FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE:

_____ THIS FINANCIAL AGREEMENT DOES NOT APPLY TO **HMO** PATIENTS UNLESS THEIR INSURANCE COVERAGE IS NOT IN FORCE AT THE TIME OF SERVICE, OR SERVICES RENDERED ARE NOT COVERED UNDER YOUR PARTICULAR PLAN.

We are committed to providing you with the best possible medical care. If you have medical insurance, we want to help you receive maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. We must emphasize that as medical providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Payment for services are due at the time those services are rendered unless payment arrangements have been approved in advance by our billing department. We accept cash, check, MasterCard or Visa. We will be happy to help you process your insurance benefits with contracting insurance companies. We may require a completed insurance form at each visit.

Returned checks and balances older than 30 days may be subject to additional collection fees. **Charges may also be made for broken appointments and appointments canceled without 24-hour advance notice.**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. However, you must realize that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies

only to companies who pay a percentage of the usual, customary and reasonable fees for the area. Thus our fees are considered usual, customary and reasonable by most companies.

This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

FINANCIAL RESPONSIBILITY WAIVER:

_____ I understand that DOHC Inc., is the medical group I have chosen to provide medical services covered under my health plan (if applicable). I am aware that if I am determined to be ineligible for any portion of the services rendered to me by DOHC, Inc., I (or my financially responsible party) am responsible for all charges related to services provided to me and I agree that I (or my financially responsible party) will pay in full all such charges.

I understand that my health plan (if applicable) has certain restrictions, limitations, and benefits, and that payment will be made on my behalf for only those benefits covered by my particular health plan (if applicable) as subject to those restrictions and limitations, regardless of medical necessity/prescriptions or authorization by the participating medical group.

NOTICE OF PRIVACY PRACTICES:

_____ I have received the notice of DOHC's Privacy Practices. Additionally, I understand this notice describes how information about me may be used and disclosed and how I can get access to this information. I have/will review it carefully.

ADVANCED DIRECTIVE:

_____ I have been informed of my right to formulate an Advanced Health Care Directive. Should I have any questions regarding this directive, I will discuss them with my health care provider.

INTERPRETER SERVICES:

_____ I have been informed of my options to request/refuse interpreter services

PRIOR EXPRESS CONSENT FOR CALLS/TEXTS/EMAIL:

_____ By providing the number for my land line and/or cell phone, I give permission and agree that DOHC and any of its affiliates, agents, service providers or assignees may call me using an automatic telephone dialing system. Additionally, I give permission for DOHC to leave any of the following: voice messages, prerecorded messages, computer generated voice messages and text messages. By providing my email address now or in the future, I give permission for DOHC to send email or other electronic messages for any reason related to any account I may establish with DOHC. For other informational purposes related to my account or treatment, I also agree that DOHC and any of its affiliates, agents, service providers or assignees may include my personal information in any Communications.

______________________	______________________	______________
Print Name of Patient	Signature of Patient	Date