CUCAMONGA VALLEY™
MEDICAL GROUP

Terms and Conditions for Treatment

Financial Policy

Basic Policy Pay for service is due in full at the time service is provided in our office. You will be subject to a $35.00 fee for any returned check.

For Patients With Insurance We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you, and you may be subject to a $5.00 reprocessing fee.

Medicare Patients We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time service is provided.

Noncovered Services Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

Personal Injury Cases This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

Assignment of Insurance Benefits *(Patients with insurances please read and sign below.)*

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Cucamonga Valley Medical Group, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all medical or other information necessary to secure the payment.

PATIENT'S FIRST AND LAST NAME *(PLEASE PRINT)*

DATE OF BIRTH

SIGNATURE OF PATIENT (*PARENT OR GUARDIAN IF PATIENT IS A MINOR)*

DATE

Medicare Patients ONLY: Signature on File *(Skip Brown Box if You Do Not Have Medicare.)*

I request payment of authorized Medicare benefits be made either to me or on my behalf to Cucamonga Valley Medical Group, Inc. for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT'S FIRST AND LAST NAME *(PLEASE PRINT)*

PATIENT'S MEDICARE NO.

SIGNATURE OF PATIENT

DATE

Cucamonga Valley Medical Group

PROVIDER

CUCAMONGA VALLEY™
MEDICAL GROUP

Terms and Conditions for Treatment

Consent to Medical Treatment:

I consent to the procedures which may be performed during office visits, including but not limited to medical or surgical treatment or procedures, x-ray examinations, laboratory procedures or anesthesia rendered under the care of the treating physician.

I have read, understood, and agreed to the above financial policy for payment of professional fees, and consent to medical treatment. **The patient is ultimately responsible for all professional fees.**

PATIENT'S FIRST AND LAST NAME *(PLEASE PRINT)*

PATIENT'S BIRTH DATE

SIGNATURE OF PATIENT *(PARENT OR GUARDIAN IF PATIENT IS A MINOR)*

DATE