WorkWell Medical Group

809 Broadway St. #D
King City, CA 93930
Tel: (831) 386-7461
Fax: (831) 386-9841

831 S. Main St.
Salinas, CA 93901
Tel: (831) 422-3701
Fax: (831) 422-3751

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Financial Responsibility Agreement

- Payment is expected at the time of service. Payment may be made by cash, check, or major credit card. Third party payment or assignment is generally accepted for services. Any deductible, co-insurance, or co-payment is payable at the time of service.
- *PAYMENT GUARANTEE:* The undersigned severally agree, whether signing as a patient or guarantor, to guarantee payment of the account in accordance with the standard rates and terms of WorkWell Medical Group, P.C. in Salinas, CA. I understand that my insurance, if any, is a contract between myself and the insurance company, except in certain cases where WorkWell has a specific contract with my PPO, HMO, or other third party payor. I further understand that any balance remaining after insurance approves or denies payment is my responsibility to pay, including any amount not paid by a secondary or supplemental insurance policy.
- If full payment is not received within 60 days of billing, WorkWell Medical Group reserves the right to charge interest of 1.5% per month (18 percent APR); WorkWell also reserves the right to charge a reasonable fee to cover its cost associated with rebilling.
- WorkWell may also check credit reports and report unpaid balances to credit bureaus. WorkWell reserves the right to transfer unpaid balances to outside entities for collection, such as banks or other financial institutions.
- The provider of service has the right to terminate services based on noncompliance of this agreement.

Release of Information

I hereby authorize WorkWell Medical Group, P.C. to release all medical information (including, but not limited to information relating to mental health evaluation and treatment, sickle cell anemia, alcohol and drug abuse diagnosis and treatment, HIV status, AIDS or AIDS related diagnoses, if any such information exists) to all my insurance carriers, other third party payors, including the Health Care Financing Administration (Medicare) or its agents, or the Social Security Administration, as may be required or requested for the processing of claims for insurance, social security, disability, or Workers' Compensation, or for other insurance purposes.

Authorization to Pay Insurance Benefits

I hereby authorize the payment of any insurance or other medical benefits directly to WorkWell Medical Group, P.C.

Notice of Privacy Practices

I have received a copy of WorkWell Medical Group's Notice of Privacy Practices.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, OR HAS BEEN READ, THE FOREGOING, THAT HE/SHE UNDERSTANDS THE FOREGOING, THAT HE/SHE HAS RECEIVED A COPY THEREOF, THAT HE/SHE HAS BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS THAT HE/SHE MAY HAVE CONCERNING THE FOREGOING, AND THAT HE/SHE IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT. THE UNDERSIGNED, HAVING READ AND UNDERSTOOD THE AGREEMENT, ACCEPTS THIS FINANCIAL RESPONSIBILITY AGREEMENT.

_____

Patient name (please PRINT) date

_____ _____

Patients signature date

_____

Responsible person (guarantor) date Relationship to patient

I have reviewed the above information and conditions with the patient or his/her representative and he/she appears to fully understand these conditions.

_____

signature of registering personnel date