



## **Patient Financial Agreement – Hyperbaric Oxygen Therapy**

Oxygen Oasis Hyperbaric Wellness Center and Oxygen Therapurity recognize the need for a clear understanding between patient and medical provider regarding financial arrangements for healthcare. I understand that a fee is charged for all visits, examinations, forms, and medical reports. I understand and agree that professional and facility services to be rendered and the fees for compensation are matters between my doctor/facility and me.

The undersigned hereby authorizes the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician and facility to submit claims and obtain benefits for services rendered, without obtaining my signature on each and every claim to be submitted for myself or dependents.

I hereby authorize my insurance company to pay and hereby assign payment to Oxygen Oasis Hyperbaric Wellness or Oxygen Therapurity all benefits. I understand I am financially responsible for all charges incurred. **Any unpaid charges are my responsibility.** Full payment is due at the time of service except if other arrangements have been made or mandated by law.

If your deductible has not been met, or a copay, or coinsurance is due, we expect payment when these services are rendered. Even though insurance will be filed, you are responsible for any balance after insurance processes your claim. **The law requires us to collect all copayments, deductibles, percentages, or non-covered services, at the time of service.** If we do not collect payments, your insurance company can charge us with fraud. All charges for treatment become due and payable sixty (60) days from the date of service. This period allows for sufficient time to process insurance. There will be a \$25 charge for all returned checks. If not paid within sixty (60) days we will begin various collection activities including, but not limited by submitting the past due account for collection activity.

### **Please note the following will apply to ALL patients:**

Appointments not canceled at least two hours prior to treatment will be charged in full. 1<sup>st</sup> time is excused, 2<sup>nd</sup> time is a charge (this includes no shows).

Arriving late to a treatment will be allowed but the time will be reduced accordingly.

There will be no refunds for advance payment of treatment, however there is no expiration date and you are encouraged to complete the treatment orders as prescribed by the hyperbaric physician.

**Medical records-** pages 1-20 \$1.44 per page, pages 21-60 \$1.06 per page, pages 60-end .35 per page.

### **I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW WHAT THE TERMS OF MY INSURANCE ARE, AND IN COMPLIANCE WITH THOSE TERMS, AGREE TO THE FOLLOWING:**

1. Provide the doctor and facility with complete and accurate billing information, but not limited to, a current insurance card, authorization/referral forms for each visit or procedure. I am responsible for the total cost if practice does not contract with my insurance plan.
2. I will pay all applicable copays, deductible, coinsurance patient balances as they become due.

### **I HAVE READ AND AGREE TO THE TERMS OUTLINED ABOVE**

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date