FINANCIAL POLICY & CONDITIONS OF TREATMENT

*** PAYMENT FOR SERVICES PROVIDED:** Payment for medical services is customarily due at the time services are provided. For your convenience we accept cash, check, Visa, MasterCard, American Express, and Discover. **Dr. Ken L. Williams is a non-contracted provider; no insurance contractual discounts are applicable at this office.** I agree to be financially responsible for payment of all medical services provided by our office and services not paid by your insurance company.

INITIAL_____

*** USUAL & CUSTOMARY RATES:** Our office is committed to providing the best treatment for our patients and our charges are considered "usual and customary" according to MAG Mutual Healthcare Solutions Physician Fee and Coding Guide for the Southern California and Orange County areas. I agree to be responsible for payment of the total billed amount of services, even if my insurance company indicates a lower reimbursement amount.

INITIAL_____

*** INSURANCE BENEFITS/ASSIGNMENT/CLAIMS: Dr. Ken L. Williams is a non-contracted provider, no discount contracts or insurance contracts (HMO/PPO/POS) exist with this private office**. As a courtesy, our office will submit the initial bill to your insurance company on your behalf. It is your responsibility to ensure that all claims are paid by your insurance company. The submission of a claim by this office does not constitute a release of liability of the claim from you. If special arrangements have been made with Dr. Williams, our office will accept payment from all insurance companies. As there are numerous insurance plans administered by insurance companies or third party administrators, you are responsible for knowing the benefits payable under your plan. Verification of insurance benefits is **not** a guarantee of payment and medical insurance may not pay for the entire cost of services, you are responsible for all unpaid claims. For services rendered I hereby assign and transfer to Dr. Ken L. Williams all rights, title, and interest in any and all benefits payable for medical services rendered by such mention professional entities. Said assignment and transfer shall be for recovery on my policy(ies) of insurance coverage for services rendered. A photo static copy of the authorization shall be considered as effective and valid as the original.

INITIAL_____

*** MISSED APPOINTMENTS:** Unless your appointment is cancelled at least 24 hours in advance by a personal conversation with our office staff (this does **not** include telephone answering service messages), our policy is to charge a missed appointment fee. This fee may range from $100 to $350 depending on each individual's treatment plan and time reserved in our appointment book. Please help us serve you better by keeping scheduled appointments.

INITIAL_____

*** ADMINISTRATIVE FEES:** Our office charges additional fees for any service not covered by an office visit fee. Services and fees include, but are not limited to: medication preauthorization, case management and telephone calls, care plan oversight, prolonged physician services, telephone calls/consultation with other providers, requests to phone in prescriptions to pharmacies, requests for information from insurance companies for prescriptions, requests for mail order prescriptions or any other medical or administrative service. A list of additional fees/charges is available upon request.

INITIAL_____

*** NON-PAYMENT FEES:** I agree that Dr. Williams reserves the right to apply the following terms if no payment is made on my account: 1) late fee charges of $35 per month; 2) Attorney fees; 3) Collection fees; 4) Annual finance charges in the amount of 21% (annual percentage rate) on the unpaid balance; 5) Returned check fee or other bank fees associated plus a rate of $25 per check handling fee.

INITIAL_____

*** AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:** I hereby give my permission to Dr. Ken L. Williams to release medical information, office notes, billing statements, and other such documents that may be requested by my insurance company for the purpose of payment of medical services or review by my insurance company for such medical authorizations or review that may be necessary for my (or my dependent's) medical care.

INITIAL_____

*** MEDICAL TREATMENT & INSTRUCTIONS FOR CARE:** I agree to adhere to the prescribed medical treatment and instructions for care; provide complete health status information for accurate diagnosis and appropriate treatment; keep scheduled appointments for care, provide adequate advance notice of delay or cancellation of appointments, and to read and understand all materials concerning my health insurance coverage/benefits.

INITIAL_____

*** MEDICARE ASSIGNMENT:** I am aware that Dr. Ken L. Williams has agreed to accept the Medicare approved payment amount for medical services, and that Medicare does not pay the entire cost of these services. I am aware that Medicare does not pay for certain preventative/health screening exams and I am responsible for the entire cost of these services. I understand that I am responsible for an annual deductible and coinsurance, which is usually 20% of the Medicare approved amount. I agree to pay for medical services that have been provided and subsequently denied by Medicare because it is not a covered expense or deemed not medically necessary under the Medicare Program.

INITIAL_____

I have read, understood, and agree to all of the above financial policy and conditions of treatment. My signature below represents my acceptance of these terms.

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Signature of Patient, Responsible Party, or Guardian Date