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**Copayment Authorization**

Dear Patient,

We are pleased that you have chosen us as your physicians and we would like to welcome you to our office. Our goal is to provide you with the best medical care possible. Please fill the attached form so that the doctor will have all of the necessary information to treat you. We would like to take this opportunity to acquaint you with our business office policies and we will be happy to answer any questions you may have.

* **Copayments are collected at the time of service and are not billable.**
* **We will bill you for any balance of your responsibility after we receive the explanation of benefits from your insurance company. Your patient balance will begin to accrue finance charges at the rate of 1 ½% per month (18% per year) from the 30th day after your bill is issued.**
* **Services are not rendered on a “lien” basis (deferral of payment pending the settlement of legal cases).** **Services are not rendered on a third party basis, meaning that we cannot bill another party’s auto insurance medical pay.**

Our staff will be happy to bill your insurance for plans which we are participating providers. It is imperative that you inform us of any changes you make in your insurance coverage, such as switching to a different insurance company, policy number or a different plan within the same company (For example, if you switch from Blue Cross Prudent Buyer to Blue Cross California Care). Please inform us of changes prior to scheduling your appointment or you may become personally liable for the charges since we do not belong to all insurances plans.

I am receiving medical services based on these financial policies as indicated above. All services from the date below will be handled as follows (check one):

\_\_\_\_\_\_\_ I have health insurance and will assign my benefits. I will pay all copayments as indicated above and will pay all charges not covered by my insurance.

\_\_\_\_\_\_\_ I have no insurance and will pay for services at the time they are rendered.

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CREDIT CARD AUTHORIZATION (Optional)**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For your convenience we accept credit card payments. You may complete this form to authorize ARC Orthopedic Group to charge your credit card once we have received your insurance companies’ payment for services.

I authorize ARC Orthopedic Group to charge this credit card for balance due after insurance has processed – Visa- MasterCard

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Card #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_