ELVIRA KLAUSE, M.D., F.A.C.S.
665 Camino de los Mares, Suite #202
San Clemente, CA 92673
Phone (949)276-8050 Fax (949) 218-1557

Patient Financial Responsibility & Acknowledgement

I hereby acknowledge my understanding and intentions to comply with the following:

1. I authorize treatment of the person named below and understand that I am ultimately responsible for the charges, regardless of available insurance benefits.

2. It is your responsibility to provide Dr. Klause and/or staf with proof of insurance and an authorization number or referral when applicable. If these items are not provided we ask that you pay in full at the time of service.

3. Dr. Klause and/or staf will submit charges to your insurance company for all medical services rendered. We will attempt to verify eligibility and benefits with your insurance company; however, this verification is not a guarantee of payment. Any expenses deemed not covered by your insurance company will be your financial responsibility. Any yearly deductible amount not met will be collected prior to your surgery date.

4. Patients who carry medical insurance should remember that the professional services are rendered and charged to the patient, not the insurance company. To avoid any misunderstanding, it is best to learn beforehand exactly what your policy will cover. In most cases, your insurance card shows a customer service number that you can use to obtain answers to your questions. We encourage you to discuss fees with us prior to any medical or surgical procedure. We do not render services on the assumption that all charges will be paid by the insurance company. Furthermore, authorization of treatment by your insurance company does not guarantee payment.

5. I agree that payment will not be delayed or withheld because of any insurance coverage, or the processing of claims. All proceeds of insurance will be assigned to this office.

6. I have been notified that my insurance company may deny payment for services. Should this occur, I agree to be personally and fully responsible for payment of services.

7. All accounts are to be paid in full within 30 days. Substantial monthly payments are expected. Payment plans should be arranged in writing. In the event that it becomes necessary to institute collection measures, I agree to pay all collections expenses and attorney’s fees.

____________________	____	__________
Print Patient’s Name	Patient’s/Authorized Representative’s Signature	Date