GRIMALDI CENTER FOR WELLNESS & AESTHETICS
John A. Grimaldi, D.O. INC
450 4th Avenue, Suite 312
Chula Vista, CA 91910
Telephone: (619) 420-0201
Facsimile: (619) 425-7795

Patient Financial Agreement

- As a courtesy to you, we will file the insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly.
- Your insurance policy including the amount of the co-payment is a contract between you and your insurance company. The doctor is not involved.
- With many insurers and other health plans, we have made prior arrangements to accept an assignment of benefits. We will bill those plans for which we have an agreement. You will be responsible for the co-payment at the time of service. You will also be responsible for any coinsurance, deductible and anything not covered by your insurance. Specific examples include injectable medications. Most insurance companies apply a 20% responsibility coinsurance amount.
- If you do not have a secondary insurance to cover the 20% responsibility for injectable medications, a fee of $100 to $150 will be due at the time of service.
- If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.
- Unless you have made prior arrangements with us in advance, full payment is due at the time of service.
- All health plans are not the same. If your health plan determines that a service you have received is not "covered," you will be responsible for the complete charge.
- For any services provided to you while in the hospital setting, we will bill your health plan. Any balance due is your responsibility.
- If you would like or need to reschedule an appointment, please call us as early as possible. There is a late cancellation or failure to show "No Show" fee of **$50.00** if you do not cancel or reschedule your appointment within 48 hours of the scheduled appointment time.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I hereby state that I have listed ALL the MEDICAL INSURANCE COVERAGE for the patient and am not aware of any other insurance(s). Otherwise, I am responsible for any claims not paid because of not informing this clinic of all medical coverages.

Signature of party financially responsible: _____

Date: _____

Patient Name: _____