Jeffrey K Pearson, D.O., F.A.O.A.S.M

Medicine-in-Motion

120 Craven Rd, Suite 101 **(760) 591-0955**
San Marcos, CA 92078 **(760) 591-3680 FAX**

STATEMENT OF FINANCIAL POLICIES

1. **Patients are responsible for payment in full for all services rendered.** Please notify the receptionist in advance if another person has assumed financial responsibility such as a parent or guardian.
2. If you have insurance, there is no way for this office to know if your insurer will pay for today's services. Insurance policies differ considerably in terms of annual deductible, co-pay amounts, place of service and many other requirements.
3. We may or may not be contracted with your insurance company. Upon your request, during regular business hours, we will be happy to contact your insurance company to verify eligibility and contract provisions before providing services. Your insurer may require treatment authorization for certain procedures. Only if we are contracted with your insurer, and your treatment has been authorized, can we accept your co-payment and bill your insurance company for the balance. **Your co-pay is required at the time of service.**
4. It is usually sufficient to attach a copy of your receipt to an insurance claim form for reimbursement. As a courtesy, we will generate claim forms to your insurance carrier to assist you in getting reimbursed for payment of services rendered in this clinic.

The undersigned requests the services of **Jeffrey K. Pearson, D.O., a.k.a. Medicine in Motion,** for evaluation and treatment. To the extent allowed by law, I (we) am financially responsible for these professional services unless I am eligible for Medicare or Medi-Cal benefits. I hereby give my consent that in the event my account becomes delinquent **Medicine-in-Motion** is authorized to release my name, account balance and further information as required to my insurance company, a collection agency, or an attorney for collection of my account. I also agree to assign to **Medicine-in-Motion** any right or cause of action I may have against any third person for payment of this account. I understand that accounts are due and payable within 60 days of the date of service. I agree to pay all service charges and accrued interest of 10% annual percentage rate if my account becomes delinquent, and to pay any collection expenses including attorney fees and costs should any action be initiated on that debt.

Furthermore, I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

I authorize payment of medical benefits to Jeffrey Pearson, D.O., Medicine-in-Motion, for medical services rendered.

_____ _____
Patient or Guardian's Signature **Today's Date**

_____
Print Name

Eligibility Guarantee

I hereby certify that I am eligible for benefits with _____ through
(Insurance Company)

_____, _____, _____as of _____
(Employer Group) **(Subscriber Name)** **(Policty #)** **(Effective Date)**

I understand that if the above is not true, I (or the person financially responsible for me) am responsible for all charges related to services provided to me. I agree that if the above is not true, I (or the person financially responsible for me) will pay in full all such charges as described in the Statement of Financial Policies above.

_____ _____
Signature **Date**