Treatment and Billing consent

By signing below, I authorize Optima Medical personnel to administer any medical, diagnostic or therapeutic treatment, as may be deemed necessary or advisable. I understand that I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

By signing below, I authorize Optima Medical to submit my health care services bill to my insurance company using the benefit explanation provided to Optima Medical during the insurance verification process. However, benefits quoted Optima Medical are not a guarantee of payment; therefore, I agree that if my insurance carrier declines payment for any reason, I understand that I will be responsible for payment of my account balance in a timely manner.

Furthermore, I understand that if my insurance company has not paid the submitted charges within 60 days from the date of service, it then becomes my responsibility to pay my account balance in full. I also understand that it is my responsibility to contact my insurance company regarding the status of my claim.

I authorize Optima Medical to release my medical records or other information necessary to process my claims. I also authorize direct payment of my medical benefits to Optima Medical.

I attest by my signature below that I understand and accept the treatment and billing policy of Optima Medical

Patient Name: ________________________________

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Patient Signature Date Signed