

Collection of Deductible/Coinsurance/Co-payment Form

Patient's Name: _____

Patient's ID Number: _____ Patient's DOB: _____

Patient's Mailing Address: _____

City: _____ State: _____ ZIP Code: _____

- I will pay for my deductible/coinsurance/copayment in full today and at the time of future services [if checked, the following does not apply].

Dear Patient,

We have verified with your insurance carrier that your insurance coverage reflects a deductible balance of \$_____. Since your insurance company has indicated that you are responsible for paying for services that fall under your deductible/coinsurance/co-payment and you have indicated that you have chosen not to pay at time of service, please check the appropriate box(es) to identify your selected payment method. Also, please indicate whether or not you have an HSA/HRA account or secondary insurance set up to help with deductible or other out-of-pocket fees.

- I authorize my provider to take an imprint of my debit/credit card. I understand that my provider will submit the claim to my insurance carrier on my behalf. Upon OGI's receipt of notification from my primary or secondary [if applicable] insurance carrier that I am responsible for any applicable deductible/coinsurance/copayment, I authorize my provider to charge my debit/credit card for any balances owed on services rendered.

- I have access to funds available through an HSA [Health Savings Account], HRA [Health Reimbursement Account], FSA [Flexible Spending Account] or secondary insurance coverage that will cover all or part of my deductible/coinsurance/co-payment and I will use, to the extent available, these funds to pay any and all outstanding balances on my account when due. Please check one of the following:

- I have a HRA/HSA debit/credit card and authorize my provider to take an imprint of my card with the following understanding: My provider will submit the claim to my insurance carrier on my behalf. Upon OGI's receipt of notification from my primary or secondary [if applicable] insurance carrier that I am responsible for any applicable deductible/coinsurance/copayment, I authorize my provider to charge my debit/credit card for my balance. I understand that I am personally responsible for any balances in excess of those available funds and will promptly pay according to my financial agreement with OGI.
- I do not have a HRA/HSA credit card associated with my insurance coverage and, in lieu of payment at the time of services rendered, will commit to the following: Upon OGI's receipt of my Explanation of Benefits from my primary or secondary [if applicable] insurance carrier, I understand that I am responsible for any applicable deductible/coinsurance/ co-payment and I must provide payment directly to my provider within **10 days** of OGI's receipt of the EOB. I also understand that this financial commitment is not dependent on a billing statement from my provider and any unpaid balance is subject to my financial agreement with OGI.

- My provider and I have agreed to a financial arrangement/payment plan to pay for any applicable outstanding balance. If I do not pay in accordance with that agreement, I understand my provider may seek alternative methods to collect these monies, including collection and legal action. As well, I understand that any surgery, non-covered services, or high-cost procedures or equipment may fall into a separate payment arrangement and that I may be asked to pay a deposit toward these services.

I understand that I am responsible for paying my provider directly for any applicable deductible/coinsurance/co-payment. This is a contractual requirement when receiving healthcare services. I understand that if I do not fulfill this requirement, my provider may notify my insurance carrier and seek alternative methods of collection. Failure to meet my obligations is a violation of my agreement with my insurance carrier and the carrier may take additional action. I understand that OGI may, at anytime, elect to charge the maximum interest allowed by state law on any outstanding balance. I further understand that if my provider collects any applicable deductible/coinsurance/ copayment from me and is also reimbursed directly from my insurance carrier, that I will be reimbursed from my provider any overpayment owed to me no later than 60 days after the provider's receipt of insurance carrier notification.

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____