O&O Alpan, LLC

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Authorizations

I hereby authorize O & O Alpan to apply for benefits on my behalf for covered services rendered. I hereby authorize payment of all Medical Insurance benefits, which are payable to me under the terms of my insurance policy, to be paid directly to O & O Alpan for services rendered. I further authorize the release of information needed in processing my insurance. I certify that the information I have reported with regard to my insurance is correct. I understand I am financially responsible for charges not paid by my insurance company. Should it be necessary to refer this account to collection, the undersigned will be responsible for the account balance, attorney's fees and collection costs not to exceed $125.00.

Most managed care insurance plans require referrals from your primary care physician. I agree that it is my responsibility to obtain the referral. If I do not bring my referral, I agree that payment is due on the date of service or my appointment will be rescheduled.

This agreement is made in Fairfax County, Virginia and shall be governed by the laws of the Commonwealth of Virginia. I understand the above and accept full responsibility.

X_____
Patient Name (Please Print)

X_____ _____
Patient/Guardian Signature Date

In order for us to file your insurance, please provide all insurance information on the day of your service including any changes in coverage. IF NOT, you will be fully responsible for the services charged on that day.
X_____ _____
Financially Responsible Party Signature Date

Please list the family members or other persons we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

Name: _____ Phone: _____

Name: _____ Phone: _____

Can detailed messages about appointment reminders be left on your telephone answering machine or voicemail?

Yes _____ No _____

X_____ _____
Patient/Guardian Signature Date

CANCELLATION POLICY

We ask that you give the office 24 hours notice of cancellation. This call needs to be made during business hours, Monday – Friday, 9:00AM – 5:00PM. If 24 hours notice is not given, the patient will be charged for the missed appointment. This charge is not billable to your insurance company and payment is the responsibility of the patient.

X_____ _____
Patient/Guardian Signature Date