Metro Comprehensive Medical Center

444 West C Street Suite 185 ♦ San Diego, CA 92101 ♦ Phone: (619) 232 - 6262 ♦ Fax: (619) 232 – 6012

Fees and Cancellation Information

I fully understand that I am directly and fully responsible for all medical bills submitted for services rendered and that such payment not contingent on any settlement, judgment or verdict by which I may eventually recover.

All fees are due when services are rendered unless prior arrangements have been made. Late fees will be applied to outstanding balances.

1. For patients with insurance coverage, please note that insurance companies are billed as a courtesy. Payments are expected when services are rendered at the time of service or a credit card can be kept on file. Payments expected may include copayments, deductibles, and/or co-insurance amounts deemed allowable, by each individual insurance company.
2. Patients being treated for a personal injury (auto accident, etc.) either with or without a lien will be charged per visit. It is your obligation to notify us the current status of the case; otherwise you will be held responsible for all charges acquired. The balance of each visit will be kept on account until the time of the settlement and reimbursement has been received.
3. Patients being seen for work comp related injuries are not responsible for the payment of their account unless injury is deemed NOT WORK RELATED in which case the patient is fully responsible for payment of the account and all aforementioned policies are immediately effective retroactive to the first date of treatment.
4. All accounts referred to an agency for collection will be subjected to collection fees, including but not limited to reasonable attorney's fees, court costs and interest.

CANCELLATIONS AND NO SHOWS POLICY: A $35 fee will be charged for all "no show" appointments. An appointment cancelled or rescheduled without a 24 hour notice will be considered as a "no show" and will be charged as such. A $15 fee is applied for patients who are more than ten minutes late to their appointment regardless of the situation. All these fees will be charged to your account. These fees are essential to the flow of patient scheduling. Please note that your insurance will not cover this fee.

I have read the above policies and understand that I am directly and fully responsible for all medical bills for services rendered in this facility. I authorize the release of any medical or any information necessary to process this claim. I also authorize payment of medical benefits to Metro Comprehensive Medical Center for services rendered.

Printed Patient Name	Signature of Patient or Parent, if patient is a minor	Date