Roy A. Meals, MD, Inc.
1033 Gayley Avenue, #104, Los Angeles, CA 90024
310 824 1262

FINANCIAL RESPONSIBILITY and ASSIGNMENT OF BENEFITS POLICIES

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to: Roy A. Meals, M.D., Inc.

I understand that it is my responsibility to pay any deductible amount, co-insurance or any other balance not paid for by the insurance carrier and any services not covered by plan provisions when applicable.

If this account is assigned to an attorney or collection agency for collection, and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.

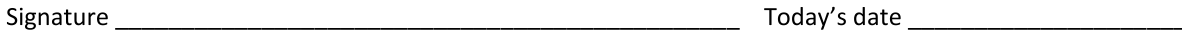
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurances.

NO SHOW and LATE CANCELLATION POLICIES

Patients not showing up for appointments or canceling on short notice delay the delivery of health care to other patients, some who have urgent problems. We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis. Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

- We will charge you $50 for an office appointment that you miss or that you cancel with less than 24 hour notice.
- We will charge you $200 for a scheduled surgery that you miss or that you cancel with less than 48 hour notice.

I agree to comply with the office's Financial Responsibility/Assignment of Benefits and the No Show/Late Cancellation policies.



Signature ____ Today's date _____________________

Patient name (please print):_____________________________________

Responsible party (please print) _________________________________

CREDIT CARD AUTHORIZATION if you choose this means of payment

I authorize Dr. Roy A. Meals, M.D., Inc. to bill the following credit card for the co-pay and/or balance remaining after my insurance has paid for assigned charges. This agreement shall remain in effect until revoked in writing.

Card type MC Visa AE Discovery Card number______________________________Good through ________

Signature ____ Today's date _____________________