

**Olathe Medical Services, Inc.**  
**Financial Policy, Consent for Treatment & Notification of Results**

Thank you for choosing Olathe Medical Services, Inc. as your health care provider. We are committed to providing quality patient care at the lowest possible cost. The following is a statement of our Financial Policy, our Consent for Treatment and our Notification of Results that we require you to read and sign prior to any services being rendered.

**Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary by your insurance carrier.**

**Participating Insurance Plans**

For those plans with which we are participating providers, all co-pays and deductibles are due at the time of service. In order to properly bill your insurance company and avoid untimely delays, we require that you provide us with accurate insurance information and allow us to maintain a copy of your insurance card on file. In the event that your insurance coverage changes to a plan with which we do not participate, refer to the following paragraph.

**Non-Participating Insurance Plans**

We do not accept assignment of insurance benefits, nor bill your insurance company. Payment is expected at time of service. Your policy is a contract between you and your insurance company.

**Minors**

The adult accompanying a minor and the parent (or guardians of the minor) are considered guarantors for the minor's account. For unaccompanied minor, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, insurance plan. Discover, Visa and MasterCard are accepted or payment by cash or check at the time of service. The above policy pertains to participating minors in relationship to the participating insurance carrier.

**Authorization to Pay Benefits to Physician/Clinic**

I hereby assign payment directly to the Clinic for medical and/or surgical benefits, if any, otherwise payable to me for services provided at the Clinic, but not to exceed my indebtedness to the Clinic for those services. I understand that I am financially responsible for charges not covered by my insurance.

**Release of Information**

I understand that OMSI may release information acquired during the course of my examination or treatment to my referring physician and/or my insurance company.

**Medication and Treatment History**

I understand that OMSI may use electronic or other means to request copies of my medication and/or treatment history.

**Acknowledgement**

I have read and understand the above Financial Policy and agree to all provisions outlined herein.

**Laboratory/Radiology**

Results are normally received within 14 days. If you have not been notified within this time period, please contact the clinic.

**Consent for Treatment**

I hereby give my **Consent for Treatment** (Medical/Surgical) by the Olathe Medical Services, Inc. Clinic staff.

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Signature of Patient or Responsible Party

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Date