James T. Wang. M.D. Inc

Financial Responsibility form

I wish to receive medical services from Dr. James T. Wang, M.D. and I authorize insurance payment to be paid directly to James. T. Wang, M.D. I understand that my eligibility for insurance coverage cannot always be confirmed at each office visit before being seen, and because benefits provided by the patient's plan is not a guarantee of payment, I understand that I will take full financial responsibility for all charges incurred for office visits and medical services provided for myself and/or for my dependents regardless of insurance coverage or in network status. If the insurance company has determined the patient is responsible for all of part of the cost of medical services (i.e. Co-Pay, Pre-existing conditions, deductibles, Co-Insurance…etc.), I understand that I am responsible for these fees and will pay the doctor promptly. I also understand and agree that:

(Initial Below)

1) $25 Fee will be charged for any returned checks _____
2) Payment of services rendered needs to be paid in a timely manner or will be subject to 1.5% interest per month. _____
3) Cash Patients and insurance Co-Pays are expected at the time of service _____
4) Patients with High Deductible plans are required to leave a card on file _____

*I agree that I have been **FULLY INFORMED** and understand my responsibilities stated above*

Patient Name: _____ Date: _____

Signature: _____

Notice of Privacy Practices: *HIPAA Acknowledgement of Receipt*

I acknowledge that I have reviewed or received a copy of the office's Notice of Privacy Practices (available at front desk) and have been given an opportunity to ask questions about the notice.

NOTICE TO CONSUMERS:Medical doctors are licensed and regulated by the Medical Board of California (800)633-2322 www.mbc.ca.gov

JAMES T. WANG, M.D. is Board Certified by the American Board of Dermatology

Sign below to acknowledge Receipt

Patient Name: _____ Date: _____

Signature: _____