Melissa Przeklasa Auth, M.D.
30131 Town Center Drive Suite # 237
Laguna Niguel, CA 92677
Office: (949) 495-6100
Fax: (949) 354-0612
occhildneurology.com

Patient Name:	Date of Birth:

Financial Agreement 2021

I understand that Dr. Przeklasa Auth is an "in-network provider" for Monarch HealthCare HMO, Mission Hospital Allied Physicians HMO, Aetna PPO, Cigna PPO, Anthem Blue Cross PPO, Blue Shield of California PPO, and United PPO. For all other insurance plans I understand that Dr. Przeklasa Auth is an "out-of-network provider" and I am financially responsible for all charges incurred for services rendered. Your insurance company requires us to collect co-payments, coinsurance, and/or deductible amounts at the time of service. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Once we receive your insurance Explanation of Benefits, if there is any outstanding balance we will notify you of the amount and *automatically charge* the below credit card within 48 hours. Any "no shows" or cancellations with less than 24 hours notice will incur a fee equivalent to the scheduled appointment $385 for a new patient appointment and $165 for a follow-up appointment. If your insurance changes, please notify us prior to your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Person Financially Responsible:

Name:_____

Cell Phone: (_____) _____

Email Address: _____

Home Address:_____

City: _____ State: _____ Zip Code: _____

Credit Card Authorization (Visa and Mastercard ONLY)
Card Type (Circle): ☐ VISA or ☐ MASTERCARD

Name on Card: _____

Card Number: _____

Home Address: _____

Verification Code: _____

Expiration Date: _____

_____

Signature

Melissa Przeklasa Auth, M.D.
30131 Town Center Drive Suite # 237
Laguna Niguel, CA 92677
Office: (949) 495-6100
Fax: (949) 354-0612
occhildneurology.com

Patient Name:	Date of Birth:

Authorization to Consent to Treatment of a Minor

I, the undersigned parent to:_____ , a minor, do hereby authorize Melissa Przeklasa Auth, M.D., as agent for the undersigned to consent to any examination, medical diagnosis or treatment which is deemed advisable and to be rendered at the office.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

_____

Signature of Legal Guardian Date

_____

Print Name of Legal Guardian

Special Letters, Forms, and Prescriptions

I understand that if I request a letter written or a form completed, describing any medical conditions and/or treatments, I will be charged a fee of $25 for this service. Any medication changes or prescriptions requested in between visits, I will be subject to a $25 charge. Controlled substance prescriptions will only be sent electronically.

_____

Signature of Legal Guardian Date

_____

Print Name of Legal Guardian