OFFICE COPY

Oscar Oo, Psy.D., ABPP, FAACP
Board Certified Clinical Psychologist, PSY 22699
4000 MacArthur Blvd., Suite 600, East Tower
Newport Beach, California 92660
Office (949) 648-3704
Fax (714) 352-6471

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

You will be financially responsible for any fees that are not covered by your insurance plan. These often include, but are not limited to:

1) Have not met deductible
2) Copayments or coinsurance
3) Provider is not in-network
4) You are not current with your insurance premiums
5) Number of sessions exceeds approved sessions
6) Pre-authorization required and not obtained
7) Service not covered or denied by insurance
8) Failure to give adequate notification of **at least 24 hours** prior to scheduled appointment for cancellations or rescheduling appointments

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I understand the above and will be financially responsible for services rendered but not covered by my insurance plan.

I understand that charges for any of the abovementioned reasons will be billed automatically to my card and will not be disputed.

I understand that Dr. Oscar H. Oo requires a credit card on file to commence services.

Card Type: ☐Visa ☐MasterCard ☐American Express ☐Discover

Credit Card Number:_____

Expiration Date:_____ CVV:_____

_____ _____
Name as it appears on card Billing Zip Code

_____ _____
Patient/Financial Guarantor's Signature Date

Please sign below to bill this credit card for regularly scheduled appointments:

_____ _____
Patient/Financial Guarantor's Signature Date