

Premier Urgent Care Center
STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Premier Urgent Care Center appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. This financial policy contains important details about billing and payments for our professional services. It outlines your responsibility as the patient and our responsibility concerning billing and payments for our services.

- Our practice participates with many health insurances companies. Our business office will submit the claim for any services rendered to a patient who is a member of one of these plans. It is the patient's responsibility to provide us with current insurance information and to confirm that our facility is participating in their insurance plan at the time of service. **The burden of proof is the patient's responsibility and not the physician's or facility's responsibility.**
- If a patient is a member of an insurance plan with which we do not participate, our office will also file the claim on the patient's behalf; however, **the patient is expected to make payment in full at the time of services.**
- It is the patient responsibility to make payment at the time of service for co-payment, coinsurance and/or deductible. Any services not covered by patient's insurance plan are the patient's responsibility and payment in full is expected at the time of services.
- It is the patient's responsibility to ensure that any required authorization or referral for treatment is provided prior to the visit. In the absence of the required authorization or referral, the patient's visit may be rescheduled or the patient may be personally responsible for payment for the services rendered by Premier Urgent Care Center.
- If you request the completion of medical forms or special letters from the physician, we may charge an administrative fee of at least \$25.00 per form/letter.
- Your **Social Security Number** is usually required to process insurance claims. If you are a self pay patient and elect to withhold your SSN, payment in full for all services rendered will be collected at the time of service. If you are insured, all co-pays, coinsurance and deductible amounts will be collected at the time of service.
- Accepted forms of payment for professional services are **CASH** and/or **CREDIT CARD**. **NO PERSONAL CHECKS ARE ACCEPTED.**

Insurance & Insurance Collections: Please understand that insurance reimbursement can be a long and difficult process for our office. Some services provided may be considered non-covered and may not be payable by your insurance plan. Your insurance policy is a contract between you and your insurance company. **If your insurance company has not paid your account in full within 90 days, the balance of your account will be due.** It is the patient's responsibility to make sure the insurance reimburses the physician for services rendered. Unresolved balances may be placed with an outside collection agency. The unresolved balances will be subject to a minimum finance charge of \$25 **AND** attorney fees and collection agency fees. Once the account has been placed in collection, future appointments may not be made until you see or talk to a representative in our billing office to pay the balance due. _____ **Initial**

Non-Contracted or Indemnity Insurance Plans: Payment is due at the time of service. Our office, as a convenience and service to you, will absorb all cost incurred for billing and filing the claim with your insurance company. Your insurance company will reimburse you directly for any payments made to our office. _____ **Initial**

HMO Plans: All co-pays must be paid for every visit. There can be no exception due to contracting and compliance rules. You are responsible for getting the proper referral information before your appointment. _____ **Initial**

PPO Plans: Our office, as a convenience and service to you, will absorb all cost incurred for billing and filing the claim with your insurance company. We have agreed to accept the discounted rates from your plan; however, co-insurance and deductibles are your responsibility. There can be no exception due to contracting and compliance rules. _____ **Initial**

Medicare: As a participating provider, we may bill your Medicare carrier. You are responsible for your 20% co-insurance and your yearly deductible. There can be no exception due to contracting and compliance rules. _____ **Initial**

Secondary Insurance: Having more than one insurer DOES NOT mean that your services are covered 100%. Secondary insurers will pay based on what your primary carrier pays. We may bill your secondary carrier as a courtesy. You are responsible for any balances or deductibles after your insurance(s) have cleared. _____ **Initial**

Self Pay: Payments is due at the time of service. You have the right to ask how much the service/test will cost before receiving it. **A minimum payment of \$120 may be required in advance from all self pay patients.** _____ **Initial**

Refund Policy: If it is determined that a refund is due to you for services rendered, your account will be credited with the refund amount and applied to a future office visit. Upon your request, a cash refund can be issued in lieu of a credit to your account. **All cash refunds will be issued within 30 days of our office's receipt of final payment from all insurances.** All refund checks will be mailed to your mailing address on file at our office unless otherwise specified. _____ **Initial**

I have read the Financial Policy. All questions have been satisfactorily answered. I understand and agree to this financial policy as witnessed by my signature and initials.

Name of Patient (print)

Signature of Patient

Date

Guarantor must sign this form if patient is less than 17 years of age. Check this box if guarantor is signing for the patient.