Office Financial Agreement

The following describes our financial policy. All patients are ultimately responsible for payment of all charges and must sign this AGREEMENT, a copy of which will be kept in your record.

HEALTH INSURANCE

We will bill Medicare and your PPO Health Plan (if we are contracted with them) as a courtesy if you present:

- A valid, current insurance card
- Valid identification
- Payment of **co-payment** when checking into the office, co-insurance when leaving the office, and/or unmet deductible.
- **Your copayment applies towards the office visit only.** All other services may have an additional copayment, which is determined at the time your claim is processed.
- Verification of insurance coverage is not a guarantee of payment. The patient is responsible for all denied charges. Any insurance disputes are between the patient and the insurance carrier.
- Our office does not accept insurance only as payment in full cannot make adjustments to your account if charges are applied towards your deductible.
- The patient's insurance coverage is a contract between the patient and their insurance carrier NOT a contract between Partners Urgent Care and the insurance carrier. It is the patient's responsibility to understand their insurance coverage, all policy limitations and preferred providers under their policy.
- Partners Urgent Care employees are not responsible for providing the patient with an explanation of their coverage, co-payments, deductibles or pre-existing conditions. Please note: Any services provided under EPO coverage will be considered out of network unless otherwise advised by the patient's insurance carrier.

The front desk employee will write in the credit card and expiration date below. Two statements will be sent to the address on record and if a payment is not received within 30 days from the last statement sent, then the below credit card will be charged the outstanding amount due. **Patient Initials_____**

Credit Card #_____Exp Date:_____ Billing Zip Code:_____ FD Intials:_____

CASH PATIENTS

Cash patients must pay, in full, at the time of service. A discount of 30% will be given for the office visit portion of the total charge. We accept cash, check, VISA, MasterCard, American Express, and Discover.

PAYMENT RESPONSIBILITY

If insurance payment is not received in full within 45 days of the date of service, the patient is responsible for payment. In the following circumstances we require payment in full at the time of service.

- Whenever we are unable to verify insurance eligibility.
- If you are involved in an auto accident.
- If you have out of state insurance we are not contracted with.

REFUNDS

Any overpayment will be refunded within 30 days of the insurance payment; however if there is an outstanding balance the overpayment will be applied.

RETURNED CHECKS

There will be a $35 fee for returned checks.

I have read the above AGREEMENT and understand and agree to its terms. I also authorize Partners Urgent Care (PUC) to furnish information to insurance carriers concerning my treatment and I hereby assign all payment for services rendered.

Patient/ Guardian Signature:_____ Date: _____

Patient Name: _____