Financial Policy, Simple Agreement, and Assignment of Benefits

Thank you for choosing Family Care Walk-In Clinic as your provider. Our practice is committed to providing you with quality and affordable health care. Our prices are representative of the usual and customary charges for our area. Please take a moment to read and sign our policy agreement. Should you need a copy, one will be provided to you upon request.

1. FINANCIAL POLICY

A. Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan with which we are in network, payment in full is expected at each visit. If you are insured by a plan with which we *are* in network but do not have an up-to-date insurance card, payment in full for each visit is required until we are able to verify your coverage. It is the patient's responsibility to be aware of and understand their insurance benefits and coverage.

B. Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles is considered fraud. Please help us by upholding the laws by paying your co-payment at each visit.

C. Non-covered services: Please be aware that some, and perhaps all, of the services you receive may not be covered or not considered reasonably necessary by Medicare or other insurers. You must pay for these services at the time of visit.

D. Proof of insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

E. Claims submission: We file your medical claims as a courtesy. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Insurance benefits are contracted between you and your insurance company; we are not party to that contract.

F. Coverage changes: If your insurance changes, please notify us before your next visit so we may make the appropriate changes to help you receive maximum benefits. If your insurance does not pay your claim within 45 days, the balance will automatically be billed to you. All accounts must be paid in full within 30 days from the first statement date.

G. Nonpayment: An account is considered delinquent if the balance is not paid in full within 60 days from your first statement date. If your account becomes delinquent, a 1% per month (12% annually) service charge may be applied to the accounts monthly balance. Any partial payments will need to be negotiated. Please be aware if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If a collection agency is assigned to the delinquent account, a 33% collection charge and reasonable attorney fees will be added to the account.

2. ASSIGNMENT OF BENEIFTS AND SIMPLE AGREEMENT

The patient authorizes Family Care Walk-In Clinic, Inc. to deposit any checks received on their account, which happened to be paid in the order of the patient's name. In addition, the patient authorizes Family Care Walk-In Clinic, Inc. to deposit any payments received in their name from any payor who submits payment to the clinic for services they've received by Family Care Walk-In Clinic, Inc. The patient also assigns their rights to payment of benefits from their insurance company to Family Care Walk-In Clinic, Inc. for services provided by Family Care Walk-In Clinic, Inc.

3. ACCEPTANCE OF FINANCIAL RESPONSIBLITY

I understand I am financially responsible for any and all charges not paid by my insurance. If the account is turned over to a third party, collection agency or attorney, I understand that a 33% service charge will be added to the balance and I understand I will be responsible to pay all litigation expenses, court costs, and reasonable attorney fees. I also understand to agree to pay a $25.00 service charge for any returned checks.

I have read and understand the financial policy, simple agreement and assignment of benefits and agree to abide by its guidelines.

Print Patient Name: ____ **Date of Birth:** ____________

Patient/Responsible Party Signature:____ **Date:** ____________