Professional Urgent Care Services, PL
Financial Policy

Patient Name: _____ **Date of Birth**: _____

Thank you for choosing Professional Urgent Care Services, PL for your care. We welcome you to our practice. We are committed to providing competent and compassionate health care. In order to better serve you, we want you to understand our financial policy.

BASIC POLICIES: Please initial each paragraph acknowledging you agree and understand each policy.

_____**INSURANCE: As a courtesy, we will bill your insurance carrier for you if proper paperwork is provided to us. Co-payments, payments and deductibles are DUE IN FULL at the time of service. Your insurance policy is a contract between you and the company. The agreement is a private one and we are not party to your contract. If services are not covered, we will have no choice but to bill you directly. We do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for your care provided. If an insurance carrier has not paid within 60 days of billing, the amount due will be your responsibility and will be payable in full by you. If your insurance carrier changes, you must notify us immediately. If insurance information is not provided within 30 days of office visit, you will be responsible for any visits during that time frame.**

_____**NONCOVERED SERVICES: Please be aware that some of the services we provide may be non-covered services or are not considered reasonable and necessary under your policy, but have been deemed to be in the best interest by your physician. Any care not paid by your existing insurance coverage will require full payment at the time of services or upon notice of insurance claim denial. Periodic preventative health services may or may not be covered under your health policy or policy may have annual limits. However, they may be required by your physician. Any care not paid for by your insurance carrier will be payable by you in full.**

_____**PAYMENTS: Payment for service is due in full at the time service is provided in our office. If you have a balance due on your account, you will receive statements from our office. The letter you receive from your insurance carrier with explanation of benefits will show amount that is your responsibility. This is considered your first statement. If no payment is received within 30 days, an additional statement will be mailed. Postage and late charges will accrue for additional statements.**

****Please remember that when you received our statement, you have already received quality healthcare from our physician. Prompt payment upon receiving your statement is appreciated.**

_____**RETURNED CHECKS: If we receive a returned check from your bank due to insufficient funds or closed account, you will be charged a $30.00 fee. This fee and account balance will be due prior to next appointment.**

_____**MINOR PATIENTS: The adult accompanying the child is responsible for full payment. If a balance is due at any time, it is your responsibility to arrange transfer of amount due to parent/adult who accompanies the child to the office. In case of divorced parents, legal payment arrangements must be worked out prior to appointment.**

ACKNOWLEDGEMENT AND AUTHORIZATION:

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance carrier, as well as co-payments and deductibles, are my responsibility. I authorize Professional Urgent Care Services, PL to release any medical or other information to my insurance company when requested.

_____ _____ _____

Signature **Date** **Printed Name**

Effective Date 4/27/2015