Emurgent Care

FINANCIAL POLICY / AUTHORIZATION

1. I understand that I am financially responsible for charges for services I receive from this practice including those not covered by my insurance. Emurgent care will submit claims for reimbursement with my insurance provider.
2. Payment will be expected at the time of service such as co-pays, co-insurance, and/ or deductibles. This practice may deny service for failure to pay such charges at the time of service.
3. I authorize the above practice to send electronic account statements and invoices to my email address on file. **It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit. I will not receive a mailed copy of any electronic statement unless requested.**
4. I agree to provide the above practice and/or payment agent with my payment information. I authorize the practice and/or payment agent to apply charges to my payment card / ACH account for all amounts owed to the practice. I understand that my signature and payment information will be saved on file digitally for future use by the practice. The payment information will be truncated and "tokenized" by the payment agent to help maintain the security of my information. Payment information will be obtained through a card swipe, void check, or manual entry in person or over the phone. I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid collections.
5. This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be canceled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

SELF PAY
We will collect **$145** prior to being seen. A **SAME DAY discount of 50%** for any additional services provided in-house such as X-ray, lab test, injections, or other office procedures must be paid at check out. If not paid same day I will be charged the full cost of these services. Emurgent care **does not collect for services outside of the clinic such as lab / radiology charges**.

NSF FEE
We will also assess a NSF fee of $35.00 for any returned check and you will no longer be able to write a check for your services

Assignment of Benefits
X_____I authorize the assignment of benefits of insurance and any overdue interest payments under the Medical Payments policy of Insurance with my insurance carrier or the responsible insurer to ***Emurgent Care, LLC*** for services rendered. *This also applies to Worker's Comp insurance/no-fault Policy of Automobile Insurance,/ Personal Injury Protection (P.I.P.) or Medical Payments.* The medical provider agrees to accept the irrevocable assignment of medical expenses.

Direction To Pay:
X_____I request that the payment authorized be made on my behalf. A photocopy of this assignment is to be considered as valid as an original. I understand that I am responsible for any applicable deductible, co-insurance, co-payments, or for any and all other services *NOT* covered by the insurance policy.

Release of Information:
*X_____I hereby authorize **Emurgent Care, LLC** to furnish my insurance company or companies, or their representatives with any information contained in my medical record needed to substantiate payment of claims.*

Acknowledgment of Receipt of Privacy Practices:
X_____Notice to patient: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information
I acknowledge that I have received a copy of Emurgent Care LLC's Notice of Privacy Practices.

***Patient Under 18: I* hereby give my permission for _____ _____to receive treatment.** X_____

Medicare Part B Lifetime Signature Authorization:
X_____I authorize any holder of medical or other information about me to release to the Social Security Administration or it's intermediary carriers or the billing agent of ***Emurgent Care LLC,*** any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for any deductibles and co-insurances.

Printed Name: _____

X_____ Relationship: _____ Date: _____
(Patient or Responsible Party's Signature