EMURGENT CARE. LLC **Financial and Payment Agreement**

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, LLC*** will submit claims for reimbursement to my insurance provider, as a courtesy to me. ***Emurgent Care, LLC*** is in network with many health insurances, but it is the patient's responsibility to verify network participation prior to their visit. I authorize this practice to disclose portions of or all of my records and information necessary to secure payment. I request that the payment authorized be made on my behalf to ***Emurgent Care, LLC***.

I am responsible for co-pays, co-insurances, and/or deductibles at time of service. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit. This practice may deny service for failure to pay such charges at time of service. I authorize this practice to send electronic account statements and invoices to my mailing address or email address on file. I understand that I could be referred to a collection agency for delinquent payment greater than 90 days. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience I can avoid interest charges by paying my bill immediately if required or by its due date. ***Emurgent Care, LLC*** reserves the right to charge 9 % APR interest on unpaid balances over 30 days. ***Emurgent Care, LLC does not collect for services outside of the clinic such as lab and radiology charges.***

UNINSURED/SELF PAY: For those without insurance and are self pays, ***Emurgent Care, LLC*** will collect $160 prior to being seen. A **SAME DAY** discount of 50% will be assessed for any services provided in addition to the office visit, such as X-ray, In-house lab tests, injections, and/or other office procedures. These must be paid upon check-out. If not paid **SAME DAY**, I may be charged the full cost of these services.

PAYMENT AGREEMENT

TODAY'S DATE: _____

Co-pays are due and collected at the time of service.
Deductibles and Coinsurance are determined after Insurance has processed. However, if you have a large deductible we require that you pay $100 towards your deductible at the time of service.
For remaining deductibles and coinsurance:

I agree to have Emurgent Care, LLC or it's authorized payment agent to charge my ACH/Credit/Debit for today's service NOT TO EXCEED the amount of $200 for any expenses for my services today that are not covered by my insurance and/or legally owed by me. If I have insurance, this transaction will occur once my insurance has been processed.

In addition, if I provide a valid email address, I will receive an email reminder 3 days before any authorized charges/debits would be processed. If the amount owed is greater than I have funds for, I can call Emurgent Care at 503-623-3199 and they will notify billing that I request an automatic payment plan that fits my budget.

I understand that this may not cover the full expenses that I may be responsible for and that any amount over the authorized amount of $200 will be billed to me by mailed statement or electronically to my email address.

In the event that the amount I paid today is more than what my insurance requires, *Emurgent Care* will refund my credit to my ACH/Credit/Debit account.

This authorization will remain in effect until I provide written notice of cancellation to the clinic. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the clinic in writing of any changes in my payment or other information.

_____ _____
Name as it appears on Card/Check Account Email Address (Required for notification)

_____
Billing address City State Zip Code

_____
Phone Number

Authorized Signature _____ Date _____