Patient Financial Policy

Patient Name: ____ **DOB:** ____________________

Thank you for choosing OnPoint Urgent Care! We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship.

Payment is Due at the Time of Service

- We accept cash, checks, debit, HSA (with Visa or MasterCard logo) and credit cards.

Initial here ______
- All co-payments, deductibles, co-insurance, past due balances and fees for services are due at the time of service unless you have made payment arrangements in advance of your appointment.

Initial here ______
- I authorize OnPoint Urgent care to maintain the following credit card on file and to charge this credit card for any outstanding balances on my account. I will receive a statement first, with the opportunity to pay with an alternative method within 14 days if I wish. If I do not make a payment within that time, we will charge the card on file.
- This authorization is valid until I provide you with written cancellation after the balance is paid in full.

____
Name on Credit Card

__________________________________ __________________________________
Billing Address for Credit Card (Street, Apt #) City, State, Zip

__________________________________ ____________________
Last four digits of Credit Card Number Expiration Date

Signature: ________________________________ Date: ____________________

Proof of Insurance

- Please bring your insurance card(s) and a valid photo ID with you to each visit.
- It is your responsibility to notify us of changes in your health insurance.

Self-Pay Accounts

- We designate accounts, **Self-Pay**, under the following circumstances: (1) patient does not have health insurance coverage (2) patient is covered by an insurance plan that our providers do not participate in, (3) patient does not have a current, valid insurance card on file, (4) patient does not have a valid insurance on file or (5) patient declines to provide a social security number.

Initial here ______
- Self-Pay patients, please be prepared to pay a minimum of [$228.00] on the date of service. There may be additional fees for in office procedures, labs, x-rays, medications, crutches, splints, castings, DME or other supplies or services.

Divorce and Child Custody Cases

- The parent who brings the child to the office for care is responsible for payment at the time of service no matter if the account is self-pay, participating insurance, or nonparticipating insurance. The Practice does not honor divorce specifics (*e.g., percentage of financial responsibility).*
- If the child has coverage with a participating insurance plan and the proper insurance identification is present at the time of service, the Practice will bill that insurance company. Applicable co-payments, coinsurance and/or deductibles are due at the time of service, unless arrangements have been made with the office prior to arrival.
- In cases of divorce, the individual who receives care is responsible for payment of co-payments, coinsurance, deductibles, and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.

Billing, Payments and Refunds

- If we must send you a statement, the balance is due in full within 14 days of the statement date.
- If you cannot pay the balance in full with 14 days, please contact our billing department to see if you qualify for special payment options.
- It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.
- We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this Practice.

___ I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

___ I authorize my insurance benefits be paid directly to **OnPoint Urgent Care.**

___ I authorize **OnPoint Urgent Care**, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

___ I authorize **OnPoint Urgent Care** to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

___ I authorize **OnPoint Urgent Care** to contact, discuss my personal health information with:

Name: ________________________________ Relationship: ____________________________

Name: ________________________________ Relationship: ____________________________

X Patient/
Guarantor
Signature ____ Date: ________________

Acknowledgement of OnPoint Urgent Care Notice of Privacy Practices

I hereby acknowledge that I have reviewed or received or have been given the opportunity to receive a copy of **OnPoint Urgent Care** Notice of Privacy Practices.

X Patient/
Guarantor Signature ____ Date: ________________