



Financial Policy
Effective 3-15-2011

Thank-you for choosing Advantage Urgent Care for your medical needs. Please carefully read and initial by each statement and sign below. This policy has been put into place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure payment for services rendered is as efficient and effective as possible. Our staff will be glad to discuss these policies with you.

1. _____ I understand if my account is not paid in full within 90 days, a 35% collection-processing fee will be added to any outstanding balance \$10.00 and above and will be turned over to Thunderbird Collection Specialist, Inc. for further processing. **Any balance of \$10.00 and below will remain on the account for future collection.**
2. _____ I understand that a \$35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. Non sufficient funds checks must be redeemed with cashiers check, money order, or cash.
3. _____ I understand that if I am covered by more than one insurance company for any date of service I am providing this information to Advantage Urgent Care at the time of service. If additional insurance carrier information is received at a later time this could result in denied claims due to timely filing limitations and will be applied to patient responsibility.
4. _____ Advantage Urgent Care will allow 60 days from the date of filing for my insurance company to process or pay a claim. Arizona law allows insurance companies operating in the state no more than 30 days to process claims. **It is my responsibility to provide my insurance company with the requested information needed to process the claim for services. It is also my responsibility to notify Advantage Urgent Care if there are any changes in my insurance coverage, residence, or phone number.**

Ultimately, it is up to ME to know MY Insurance Benefits.

5. _____ (Initial If applicable) I have been notified that my insurance is out of network and I understand that my visits may not be covered by my insurance.
6. _____ I have read and understand the above Financial Policy and I agree to abide by its terms.

This agreement shall remain in effect for one year from the signature date and/or must be updated with any changes to insurance or demographic information.

Printed Name of Patient

Signature of Patient/Responsible Party

Date

Relationship of Responsible Person to Patient