

Financial Policy

Welcome to Premier Urgent Care! We are so glad that you've chosen us to provide your medical care today! If you have any questions regarding our payment policies, please ask us before your visit.

In Network and Auto (Accident) Insurance

We will submit your insurance claims for you. If you have had an auto accident, we will also require the claim number and mailing address of the insurance company. Please note that you are responsible for your copay at time of service. If coverage is denied for any reason, you will be responsible for the entire amount of your bill. **We have no way of quoting patient responsibility in advance. Individual insurance contracts vary, and we bill usual and customary fees according to our agreements with them. Your costs will be determined upon the completion of claims processing according to your individual insurance plan.**

Tricare Prime patients only: You are required to obtain an authorization to be seen. It is the patient's responsibility to obtain this referral. Ideally, this should be done prior to treatment. If this is not possible for whatever reason, then it is critical that you contact your PCM within one business day for this authorization. If authorization is not obtained, Tricare will apply the allowed amount for the visit to your deductible. If you receive a bill for your deductible, it is your responsibility to contact Tricare for payment.

Out of Network Insurance

If you have insurance that is not listed on our contract list, you will be expected to pay the "no insurance" rates as listed below in full at time of service **or** we will courtesy bill your insurance one time. If no payment is made by your insurance, we will accept your "no insurance" payment as payment in full. If your insurance pays, we will issue you whatever refund may be due once we receive payment from your insurance. Refunds may take up to 60 days for processing. If you choose for us to bill your insurance and NOT pay the "no insurance" rates at time of service, please note that you may be billed the entire amount of your bill should your insurance deny your claim for any reason.

No Insurance/International Insurance

If you do not have insurance or have international insurance, we expect you to pay for your visit in full at time of service. We will collect \$114 up front in order to see a doctor. Additional charges may apply depending on the extent of the visit and will be collected at the end of your visit. Our "no insurance" price sheet is available at the front desk. These rates are **ONLY** for patients with no insurance, out of network, or international insurance and are due at time of service. No discounts will apply if payment is not made immediately.

Work Related (Work Comp)

The EMPLOYEE is responsible to report the Work Comp injury/illness in writing to the employer within four (4) days.

The EMPLOYER is responsible to fill out and mail a First Report of Injury to their insurance carrier within ten (10) days of injury notification.

The INSURANCE CARRIER is responsible to pay within thirty (30) days of receiving the Work Comp claim.

If the EMPLOYER fails to file the First Report of Injury, the EMPLOYEE must file his/her own First Report of Injury or be responsible for the bill.

If the INSURANCE CARRIER denies the claim for any reason, the patient (EMPLOYEE) will be responsible for the bill.

Assignment of Insurance Benefits and Payment Guarantee

In consideration of services provided by Premier Urgent Care, I hereby assign and transfer to Premier any and all rights, which I have against insurance companies, governmental agencies, or third party payers, for payment of charges for services provided by Premier Urgent Care to me or to one of my dependents. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies, governmental agencies or third party payers. In consideration of services to be provided, I agree to pay Premier Urgent Care in accordance with the regular rates and terms of Premier Urgent Care. I further agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with Premier Urgent Care. I authorize said payments to be applied to any unpaid Premier balance for which I am responsible. Returned checks are subject to a \$25 service charge. Any balance over 60 days will acquire an interest rate of 12% annum. If my account is placed with a collection agency, an additional 25% will be added to my balance. I also agree, by my signature below, to pay all reasonable costs of collection including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs and understand that I may no longer be a patient at Premier Urgent Care. I have read and understand the payment policies and have been given the opportunity to ask questions about these policies. I understand my responsibility for payment of my account with Premier Urgent Care, and have provided to the best of my ability the information requested accurately and completely.

Signature of Patient/Guarantor _____ Date _____