DUBLIN PRIMARY CARE

FINANCIAL POLICY

The providers and staff at Dublin Primary Care are committed to meeting your healthcare needs. The providers will always make clinical/medical decisions based on the welfare of the patient. We are dedicated to the health maintenance as well as attending to your acute care and illnesses.
It is essential that you understand your health insurance, benefits and requirements. Medical recommendations may not be covered under your insurance plan and you may have a higher out of pocket cost.

- We ask that you present your insurance card to us at ***every visit.*** If you fail to provide us with the correct insurance information, you will be responsible for payment for all services provided.
- Dublin Primary Care is contracted with most insurance carriers and we will submit your claims on your behalf. It is the member's responsibility to comply with any requests from your insurance carrier for information. This will avoid delays in the processing of your claims.
- Please be aware that any services rendered at our office may or may not be covered by your insurance carrier. You are financially responsible for any unpaid services.
- Copayments are collected at the time of service. For self pay or uninsured patients we require a minimum $50 deposit at time of service.
- Deductibles, coinsurances or any other financial liability designated by your carrier as patient responsibility are required to be paid within thirty (30) days.
- We accept Cash, Check, Money Order, Visa, MasterCard, and Discover. We do not accept post dated checks.
- We can secure your credit card on file to allow scheduled payments to be charged to your credit card for unpaid balances.
- If you are unable to pay balances in full we will set up a payment arrangement that will fulfill your financial responsibilities.
- If you do not meet your payment arrangement obligations, we will require a credit card on file for all future services.
- Unpaid balances over sixty (60) days will be referred to a collection agency and your family may face possible dismissal from our practice.
- You will be assessed a $50 No Show Fee for any appointments that are not cancelled within four hours of the scheduled appointment.
- Legally and ethically, we can only submit claims to the insurance companies or patients for actual services rendered. The providers do not code according to your insurance benefit levels. They will only code for services provided.

Use the space below to list yourself, and any minor children that you are accepting financial responsibility for. Please include birthdates. <u>Do not</u> include your spouse, significant other, or other adult members of your household that are seen here.

Patient Name & Date of Birth	Patient Name & Date of Birth	Patient Name & Date of Birth
Patient Name & Date of Birth	Patient Name & Date of Birth	Patient Name & Date of Birth

Please use the back of this form for any additional Patient names.

Printed Name of Responsible Party	Signature of Responsible Party	/ / Date