Patient's Name: _____ Date: _____

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing quality care and Service to all of our patients. The following is a statement of our financial policy, which we require that You read and agree to prior to any treatment.

It is your responsibility to know your own insurance benefits, including whether we are a Contracted provider with your insurance company, your covered benefits and any exclusions in Your insurance policy, and any pre-authorization requirements of your insurance company

As a patient of University Medical Care, PA I have been informed of the following:

- It is my responsibility to know if there are any deductibles, copays, clauses and/or exclusions in my insurance policy that would prevent the insurance company from paying any of my claims.

- It is my responsibility to provide University Medical Care, PA with accurate insurance information to submit claims on my behalf. Should you failed to provide this information you will be financially responsible. We will need a copy of your insurance card and photo ID.

- My insurance company may not cover ALL physician fees, and I will be responsible for payment if my insurance company denies payment

- It is my responsibility to obtain physician referrals if needed. If a referral is not obtained, but treatment is provided as an emergency you are still responsible.

- The insurance company denies payment; it is my responsibility to make payment for any outstanding charges.

- The office bills my insurance company for all visits, office procedures and laboratory fees performed IN office. Any questions related to outside bills should be directed to whoever provided the services.

- I understand that some insurance companies have timely filing limit reference to submission of medical claims. I understand that information in regards to correct insurance policies must be given to the office within that time frame or I, as the patient, am solely responsible.

My signature below indicates that I understand the information explained above. I acknowledge my financial responsibility for all charges including all reasonable costs, expenses, including court and attorney's fees incurred in pursuing collection of such charges.

_____ _____

Signature of patient or legal guardian **Date**