1910 Highway 35 South• Oakhurst, NJ 07755 • Phone: 732-531-0100• Fax: 732-531-0144
Web: www.familyfirst-urgentcare.com

FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Payment is due in full at the time services are rendered. We accept cash and credit cards.

PATIENTS WITH INSURANCE: We will bill all accepted primary and secondary insurance companies so as the provided paperwork is properly completed and all insurance information is correct. Co-payments and deductibles are due at the time of service. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you**.** Should payment be sent directly to you, it is your responsibility to forward payment directly to the physician**.**

NON-COVERED SERVICES: Any care not paid for by your insurance coverage will require payment in full at the time of services are provided or upon notice of insurance claims denial. Please be aware that some services provided may not be covered and/or considered reasonable and necessary under the Medicare program and/or other medical insurance if the provider is non-participating with the insurance company. Physical exams, well child visits, immunizations, and cosmetic skin surgery may be non-covered services under your health insurance policy.

Initial the following for consent

_____ **COMPLETION OF FORMS**: $25.00 to complete physical/pre-employment/sports physicals/insurance requests forms if not provided at time of service.
Please allow at least 48-72 hours for completion.

_____ **COLLECTIONS:** A $50.00 late fee will be issued if all balances are not paid within 20 days of statement. Any fees or surcharges imposed by a collection agency will be your responsibility, along with the full outstanding balance from your visit. Prompt payment of outstanding balance prior to collections may result in waiver of the $50 late fee.

_____ **MEDICAL RECORDS:** Request for medical records must be made in writing. Please allow **at *least 72 hours*** for completion.

_____ **I authorize the release of any information necessary to process the health claims for my care.**

_____ **I authorize the insurance company to forward payment directly to the physicians.**

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**