Print Form

Personal Choice HealthCare PC

Financial Policy and Agreement

Our commitment is to provide you with the best possible medical care. Our relationship is with you, our patient. All charges for service are ultimately your responsibility. We will work with you to maximize your insurance benefits for needed services. We cannot guarantee payment or coverage by your insurer. We ask that you understand your insurance plan. You are responsible for any and all noncovered services. Contact your insurer and your employer's human resource department to clarify any concerns you may have regarding your health coverage benefits.

If we participate with your insurance plan, you are responsible for any co-payments, co-insurances and deductible amounts. We are contractually obligated to collect these payments. Should you desire a service, test or procedure that is not approved by your insurer, we can arrange to provide it once payment arrangements have been made. If your insurer denies payment for service because of exclusion for pre-existing condition or exclusion by rider, or as noncovered service, you shall be responsible for the balance in full. If payment is not received for any claims pending with your insurance company within 45 days, we will look to you for payment. Charges incurred for services provided as a result of motor vehicle accidents or workers compensation are due in full at the time of service unless prior arrangements have been made.

Payment is due at the time of service. We accept Cash, Check, MasterCard, Visa, and Discover Card.
We are unable to accept 50 or 100-dollar bills.

Unless prior arrangements have been made, your balance is due within 15 days after insurance has paid. Personal balances over thirty days old shall be assessed interest and/or statement charges. Checks returned to us by the bank for non-sufficient funds will be charged a $30.00 fee. Please respond promptly to your insurance company when they request additional information from you. The balance due will be your responsibility until payment has been received from you insurance company. In the event that this account is placed with our collection agency, you will be responsible for any collection agency fees, plus reasonable attorney's fees and court costs if applicable.

Please bring your current insurance information and your insurance card with you to each of your appointments. We must have this information in order to file your claims. We do not obtain insurance information from other patient charts. If you do not provide us with your up to date insurance information, you will be responsible for any balance denied by your insurer. If you have provided incorrect insurance information and request that we refile your claim, there will be a $20.00 refiling fee paid at the time of the request. You will remain responsible for any balance denied by your insurance company for lack of timely filing.

If you are not covered under an insurance plan we contractually participate with, payment is due in full at the time of service unless prior arrangements have been made. Upon payment in full, we will provide to you a statement that contains the information your insurance company needs to process your claim. Attach this form to your insurance company's claim form with the patient section completed, and mail it to your insurance company to request your reimbursement.

Patient balances over 30 days will be subject to a $10.00 statement fee for each additional statement sent until the account is current and 1.5% per month interest fee on the overdue balance.

We will make every effort to answer questions you may have regarding your account. Please do not hesitate to ask us. We are here to help you. Thank you for choosing Personal Choice HealthCare to provide your healthcare.

_____		_____
Patient Printed Name	Patient Signature	Date
_____		_____
Guarantor Printed Name	Guarantor Signature	Date