Financial Policies

Insurance: Filing insurance claims are a courtesy we extend to our patients and is not a guarantee of payment. It is your responsibility to ensure that the office has accurate insurance information. It is your responsibility to contact your insurance company **PRIOR** to your appointment and verify your benefits and verify your provider is a contracted provider in your network. If, for any reason, your insurance claims are denied, the patient becomes solely responsible for payment of the services. **Initials:_________**

Co-Pays and Deductibles: All co-payments are due at the time services are rendered. Deductibles are due on receipt of an explanation of benefits from your insurance carrier. Please be prepared to pay towards your deductible and/or patient responsibility at the time. Payment plans will be considered and discussed on a case by case basis. **Initials:_________**

Non-Covered Services: Some of the services that you receive may be a non-covered benefit. You must pay for these services at the time they are rendered. Please note, a check of eligibility is not a guarantee of payment on your behalf from your insurance carrier. **Initials:____________**

Non-Payment: All payments are due immediately and in full unless otherwise agreed upon with written documentation. Failure to do so within 90 days will result in your account being sent to an outside collection agency. **Initials:______**

I certify with my signature below, that I authorize medical treatment of the person named below and I agree to the financial agreement as outlined above. I authorize payment of my insurance benefits be made directly to SoCO Primary Care Clinic for any service rendered by the nurse practitioner employed by the office. I authorize the release of medical information needed to complete insurance claims and to coordinate care with outside physicians, providers, laboratories, pharmacies, or facilities. A photocopy or scanned copy of this release is as valid and effective as the original.

Patient/Guardian Signature:________________________________ **Date:______________**

Patient Printed Name:_______________________________ **Date of Birth:_____________**