8186 Lark Brown Road Elkridge MD 21075
10981 Johns Hopkins Road Laurel MD 20723
(410) 730-3399

PATIENT FINANCIAL AGREEMENT & ACKNOWLEDGEMENT OF OFFICE POLICIES

CENTENNIAL MEDICAL GROUP/FIRST CALL URGENT CARE BELIEVES THAT PART OF GOOD HEALTH CARE PRACTICE IS TO COMMUNICATE WITH OUR PATIENTS. WE ARE DEDICATED TO PROVIDING THE BEST POSSIBLE CARE FOR YOU, AND WE WANT YOU TO HAVE A FULL UNDERSTANDING OF OUR POLICIES.

1. **PAYMENT** IS EXPECTED AT THE TIME OF YOUR VISIT. WE ACCEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER, AND CARE CREDIT ON SELECT PROCEDURES. PAYMENT WILL INCLUDE ANY UNMET DEDUCTIBLE, CO-INSURANCE, CO-PAYMENT AMOUNT, AND CHARGES NOT COVERED BY YOUR INSURANCE COMPANY. IF YOU DO NOT CARRY INSURANCE, OR IF YOUR COVERAGE IS CURRENTLY UNDER A PREEXISTING CONDITION CLAUSE, PAYMENT IN FULL IS EXPECTED AT THE TIME OF YOUR VISIT. ALL NON-FILED SERVICES ARE EXPECTED TO BE PAID AT THE TIME OF SERVICE.

2. **INSURANCE**: WE PARTICIPATE WITH MOST INSURANCE PLANS. WE WILL FILE ALL OF THE CLAIMS FOR THESE PLANS. PLEASE REMEMBER THAT INSURANCE IS A CONTRACT BETWEEN THE PATIENT AND THE INSURANCE COMPANY AND ULTIMATELY THE PATIENT IS RESPONSIBLE FOR PAYMENT IN FULL. AS A COURTESY TO OUR PATIENTS, WE WILL VERIFY YOUR INSURANCE COVERAGE; HOWEVER, OUR VERIFICATION IS NOT A GUARANTEE OF BENEFITS PAYABLE BY YOUR INSURANCE. IN ORDER TO BILL YOUR INSURANCE AND TO MEET FILING GUIDELINES WE DO ASK FOR A COPY OF YOUR INSURANCE CARD AND A PHOTO ID. IF OUR PROVIDERS ARE NOT LISTED IN YOUR PLAN'S NETWORK, YOU MAY BE RESPONSIBLE FOR PARTIAL OR FULL PAYMENT.

3. **POLICY ON NON-COVERED SERVICES**: THIS OFFICE OFFERS ACCESS TO MANY MEDICAL SERVICES AND PROCEDURES; SOME OF THEM ARE DEEMED AS "NOT COVERED" BY INSURANCE. IN SOME CASES, YOU WILL BE GIVEN AN ABN (ADVANCED BENEFICIARY NOTICE) FOR THESE TYPES OF SERVICES/PROCEDURES BEFORE THEY ARE PROVIDED/PERFORMED. YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL AT THE TIME OF SERVICE.

4. **INCURRED CHARGES**: PLEASE BE ADVISED, INSURANCE WILL BE BILLED FOR ANY ADDITIONAL TREATMENTS YOU MAY RECEIVE, INCLUDING, BUT NOT LIMITED TO: SCREENINGS, COUNSELING, AND PHONE CONSULTS. IF DURING A PREVENTIVE EXAM, A NEW ABNORMAL FINDING OR A PREEXISTING PROBLEM IS SIGNIFICANT ENOUGH TO REQUIRE ADDITIONAL WORK THAT MEETS THE KEY COMPONENTS OF A PROBLEM-ORIENTED SERVICE, IT WILL BE REPORTED TO YOUR INSURANCE. THESE ADDITIONAL SERVICES MAY BE SUBJECT TO COPAYMENT OR COINSURANCE.

5. **FEES**: RETURNED CHECKS WILL INCUR A $50.00 SERVICE CHARGE. OUR NO-SHOW FEE IS $35.00. WE UNDERSTAND THAT CERTAIN SITUATIONS ARISE WHERE YOU ARE UNABLE TO MAKE YOUR APPOINTMENT, BUT WE ASK THAT YOU PLEASE PROVIDE US WITH AS MUCH NOTICE AS POSSIBLE.

6. **RESPONSIBILITY FOR PAYMENT:** I UNDERSTAND THAT I, PERSONALLY, AM FINANCIALLY RESPONSIBLE TO CENTENNIAL MEDICAL GROUP/FIRST CALL URGENT CARE FOR CHARGES NOT COVERED BY THE ASSIGNMENT OF INSURANCE BENEFITS AND ALL NON-COVERED CHARGES.

I HAVE READ AND UNDERSTAND THE PRACTICE'S OFFICE AND FINANCIAL POLICIES

_____ _____

SIGNATURE OF PATIENT/GUARANTOR **DATE**

_____ _____

PATIENT NAME (PRINT) **DATE OF BIRTH**