First Choice Medical Care, PLLC
Patient Financial Responsibilities

Every effort is made to keep the cost of your health care services to a minimum. In keeping with this effort we request your assistance in the following areas:

- You are responsible for all charges. We file insurance as a service to our patients it is your responsibility to provide us with accurate information in a timely manner. Failure to do so could result in your incurring unnecessary expense.

- You are responsible for knowing your insurance benefits, their protocols for being seen by a specialist, and the lab network they utilize. Please make the staff aware of these so that we can ensure you do no incur unnecessary expense.

- Full payment of charges will be expected if you do not present an insurance cart at the time of visit. If no insurance is to be filed there is a discounted rate available for payment in full. Once discounted rate is given insurance for that date of service will not be filed.

- The portion of the visit not covered by your insurance will be expected at the time of the visit. This includes all unmet deductibles, co-insurance and co-payments. Insurance benefits will be verified at the time of service.

- Patients will be expected to make full payment on previous unpaid balances unless prior arrangements have been made.

- For your convenience, we accept Cash, Visa, Mastercard, American Express, Money Orders and Personal Checks. ($35.00 returned check fee applies)

- Refunds of overpayments will be cheerfully refunded upon your request.

- Failure to meet your financial responsibility may result in your being denied further medical treatment.

I understand and agree to my financial obligation as outlined above and therefore consent to treatment by the providers and staff of First Choice Medical Care, PLLC. If needed, I authorize the release of any information concerning me or my child's health care, advice and treatment for the purpose of evaluating and administering claims to the insurance carrier on behalf of my benefits. I further agree to authorize payment of insurance benefits to be made payable to this clinic.

Signature of Patient/Guarantor: _____
Date: _____ Witnessed by: _____