ELECTRA
MEDICAL CLINIC

ELECTRA MEDICAL CLINIC FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibilities.

- ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING A PROVIDER.
- FULL PAYMENT IS DUE AT TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, DISCOVER and AMERICAN EXPRESS.

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, (his/her parents or guardians) are responsible for full payment at the time of service.

REGARDING INSURANCE

Insurance is a contract between you and your insurance company. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, copayments, covered charges, secondary insurance, usual & customary charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account. If your insurance company pays more than the balance due, we will send a refund check to you at month end.

MEDICARE / MEDICAID / CHAMPUS / WORKER'S COMPENSATION

If you are covered by Medicare, Medicaid, Champus, Worker's Compensation, or any other government sponsored program, please discuss your payment situation with our office staff prior to the date of service.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Signature of Responsible Party _____ Date _____

Primary Insurance _____ Policy # _____ Grp# _____

Secondary Insurance _____ Policy # _____ Grp# _____

Other Insurance _____ Policy # _____ Grp# _____

Payment Authorization: I authorize the release of any medical information necessary to process this claim. I also authorize payment of all medical benefits to the provider for services rendered from those providers. I understand that I am financially responsible to the provider for charges not covered by the authorization.

Insured_____ Date_____

MEDICARE/MEDICAID AUTHORIZATION. I request that payment of authorized Medicare and/or Medicaid benefits be paid to Tom DeLizio, MD; Electra Memorial Hospital; Ben Segler, FNP-C; Duron Cranford, NP-C; Kelly Warren, NP-C; or Chris Reece, NP-C, for any service rendered to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and to its agent any information needed to determine the benefits payable for related services.

Signature_____**Date**_____