Surfside URGENT CARE OF LAGUNA BEACH

IMPORTANT: PLEASE READ OUR POLICIES BELOW BEFORE SIGNING.

FINANCIAL RESPONSIBILITY

ALL CO-PAYMENTS, CO-INSURANCES, AND DEDUCTIBLES ARE DUE AT THE TIME SERVICES ARE RENDERED. IF YOU ARE NOT INSURED, ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE.

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ACCEPTABLE FORMS OF PAYMENT INCLUDE DEBIT CARD, CREDIT CARD, AND CASH. WE DO NOT ACCEPT CHECKS OR AMERICAN EXPRESS.

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INITIAL

IF WE ARE BILLING YOUR INSURANCE FOR SERVICES RENDERED, YOU WILL BE RESPONSIBLE TO PAY FOR YOUR ESTIMATED PATIENT RESPONSIBILITY BASED ON OUR VERIFICATION OF YOUR BENEFITS THAT WE WERE ABLE TO OBTAIN PRIOR TO YOUR VISIT. PLEASE NOTE THAT VERIFICATION OF YOUR INSURANCE BENEFITS IS NOT A GUARANTEE OF PAYMENT BY YOUR INSURANCE COMPANY.

IF WE ARE UNABLE TO VERIFY YOUR INSURANCE ELIGIBILITY AND BENEFITS PRIOR TO YOUR VISIT, YOU WILL BE RESPONSIBLE TO PAY FOR ALL SERVICES RENDERED BASED ON YOUR INSURANCE'S ESTIMATED DISCOUNTED RATES. YOUR INSURANCE WILL BE BILLED FOR THE SERVICES RENDERED. ONCE OUR OFFICE RECEIVES THE EXPLANATION OF BENEFITS FROM YOUR INSURANCE, YOU MAY BE BILLED FOR ANY ADDITIONAL PATIENT RESPONSIBILITY OR REFUNDED/CREDITED FOR ANY OVERPAYMENT COLLECTED BY OUR OFFICE. **PLEASE ALLOW 4 TO 6 WEEKS FOR YOUR INSURANCE TO PROCESS EACH CLAIM**. PLEASE CONTACT OUR OFFICE IF YOU HAVE ANY QUESTIONS OR CONCERNS ABOUT OUR BILLING PROCEDURE.

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IN-HOUSE PHARMACY

FOR YOUR CONVENIENCE, OUR OFFICE CAN DISPENSE SOME PRESCRIPTION MEDICATIONS NECESSARY TO TREAT YOUR MEDICAL CONDITION. PLEASE NOTE THAT OUR OFFICE DOES NOT BILL YOUR MEDICAL INSURANCE FOR MEDICATIONS DISPENSED IN OFFICE AND THAT YOUR PHARMACY INSURANCE BENEFITS DO NOT APPLY TO MEDICATIONS DISPENSED IN OFFICE. **ANY MEDICATIONS DISPENSED IN OFFICE ARE THE PATIENT'S RESPONSIBILITY AND ARE AN ADDITIONAL CHARGE TO YOUR RESPONSIBILITY FOR THE OFFICE VISIT.** FOR INQUIRIES REGARDING OUR MEDICATION PRICES, PLEASE FEEL FREE TO ASK ANY OF OUR STAFF MEMBERS. IF YOU PREFER TO USE AN OUTSIDE PHARMACY OF YOUR CHOICE, A PRESCRIPTION MAY BE PROVIDED TO YOU AT NO ADDITIONAL CHARGE.

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I, _____ have read and understand the above stated office policies.

Print Patient Name

Signature: _____ **Date: _____**