MEDFAST Urgent Care Centers

**FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS FORM**

**ALL SERVICES RENDERED AT MEDFAST URGENT CARE CENTERS SHALL BE BILLED AND PAYABLE AT THE TIME OF SERVICE. IF YOU ARE REFERRED TO THE EMERGENCY ROOM OR SPECIALIST, WE WILL NOT ISSUE A REFUND FOR YOUR SERVICES.**

At this time, we accept cash, Visa, MasterCard, and Discover as forms of payment. All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

We will accept Checks on a case-by-case basis. If your check bounces we will charge you an additional $60.00 fee for bounced checks. If the balance plus additional administrative check fees are not paid within 90 days, the account will be turned over to an outside collection agency.

**ANY BALANCE ON YOUR ACCOUNT THAT HAS EXCEEDED 90 DAYS WILL BE TURNED OVER TO AN OUTSIDE COLLECTION AGENCY FOR FURTHER ACTION. THE PATIENT WILL THEN BE RESPONSIBLE FOR ANY CHARGES THAT ARE INCURRED IN SUCH ACTION AND MAY BE RESPONSIBLE FOR ANY AND ALL LEGAL FEES.**

Please be aware that some services may not be covered under your insurance policy, it is your responsibility to know the limitations and guidelines of your insurance policy. MedFast Urgent Care Centers will not enter into any disputes with your insurance company, but we can assist you with any difficulties.

- Any laboratory tests, injections or procedures done in the office are not included in the office visit and **WILL** result in an additional charge to you or your insurance company.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment checks(s) directly to MedFast Urgent Care Centers for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I fully understand that I am ultimately responsible for any amount not covered or denied by my insurance.

Authorization of Treatment

I hereby authorize medical services from MedFast Urgent Care Centers on behalf of myself and/or my dependents, and understand that by authorizing treatment, I became fully financially responsible for any and all charges incurred in the course of the treatment. I hereby authorize MedFast Urgent Care Centers and staff to perform any procedures, treatment, or medication in connection with my diagnosis and/or my dependents diagnosis and treatment plan.

I further understand that fees are due at the time of service. I accept financial responsibility for the charges incurred for my visit to MedFast Urgent Care Centers, LLC and I will pay all Co-pays, Co-insurance, deductibles and any outstanding balances I am responsible for. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient / Responsible Party Signature Date

_____ _____

Witness Date