Jeramiah Walker APRN-CNP | Board Certified Family Nurse Practitioner

FINANCIAL RESPONSIBILITY POLICY

In seeking medical care you obligate yourself to compensate the practitioner for their services. As a patient of TRI-CITY FAMILY CARE you are required to fill out and sign all forms prior to being seen by the practitioner. Failure to do so may require your appointment to be rescheduled.

Account Information: It is your responsibility to notify the office of any name, address, or phone number changes. If you are unable to keep an appointment, please notify the office as soon as possible to prevent a possible no show fee.

Insurance: You are required to provide your insurance card so that it can be scanned into our system. It is your responsibility to notify us if your insurance changes. Insurance companies have a filing deadline, so failure to provide us with the correct insurance information at the time of service may result in your being responsible for the entire bill. Please check with your insurance to determine if the doctor you are seeing is a contracted provider. All copays will be collected at the time of service. You are responsible for any deductibles, denials, etc. and agree to submit payment to TRI-CITY FAMILY CARE immediately upon notification of responsibility from your insurance company. In the event that your insurance company denies payment for services rendered, you will be personally and fully responsible for those charges. Failure to comply can result in your account being turned to a collection agency and possible termination as a patient.

Non-Insured Patients: You are expected to make payment in full on the day the service is rendered unless other arrangements have been made.

Forms of Payment: We accept Cash, Debit Cards, Visa, Master Card, and Discover. Payment plans are available.

Work Comp: We will file your work comp claim provided that we have received authorization from your adjuster. NOTE: If you notify the clinic your injury is work related we will not file your health insurance.

Release of Information: I hereby authorize release of all information from TRI-CITY FAMILY CARE. TRI-CITY FAMILY CARE may disclose any or all of the patient's information for insurance claim purposes. If some other party is paying the patient's bill or by any contract may be expected to pay the bill, then TRI-CITY FAMILY CARE may disclose any or all of the patient's information to that party to verify charges. TRI-CITY FAMILY CARE may disclose any or all of the patient's information all health care providers who have a legitimate need for such information which indicates the presence of a communicable or venereal disease (such as Hepatitis, Syphilis, gonorrhea, Human Immunodeficiency Virus also known as A.I.D.S.) and/or presence of alcoholism, drug abuse and mental health problems.

I have read the Financial Policy of TRI-CITY FAMILY CARE and agree to comply. I agree to treatment by the practitioner. In addition, I understand that I am financially responsible for services rendered by the practitioner and authorize my insurance company to pay benefits directly to the practitioner.

______________________________ ______________________
PATIENT SIGNATURE DATE

______________________________ ______________________
SIGNATURE (Spouse, Guardian, Responsible Party) DATE

Business Medical Systems, Inc. (405) 685-0177
TRC383 Form# R-007 (01/14)