



Medicaid Patients

I understand that Xpress Urgent Care is not a provider for Medicaid. I accept full financial responsibility for any/all medical services provided by Xpress Urgent Care. Incurred charges will not be submitted to my Medicaid Insurance for reimbursement.

Medicare and or Governmental Insurance Verification / Authorization

I understand that my insurance has not been verified and that my claim will be submitted to my carrier. I am accountable for all charges if my insurance company denies payment and may receive a statement for any balances owed.

Insurance Non-Covered Service & Insurance Out –of-Network

Non-Covered Services - I understand that charges for services or treatment rendered by Xpress Urgent Care and their staff may **not be covered** by my insurance and I am fully responsible for all medical service charges. I agree that I will not hold my insurance company or Xpress Urgent Care responsible for reimbursement.

Out-of-Network – I understand that Xpress Urgent Care, may not be an approved provider for my insurance plan or I may not have Out-of-Network benefits. I will pay the co-pay or good faith deposit and will receive an additional statement for any charges not covered by my insurance. Prices are subject to change per Xpress Urgent Care fee schedule. I will not hold my insurance company or Xpress Urgent Care, responsible for reimbursement.

I understand that Xpress Urgent Care, will make all reasonable attempt to verify my medical benefits with my insurance company. If Xpress Urgent Care is unable to verify benefits for any of the following reasons:

- Unable to obtain authorization from Corporate Account
- Unknown Copayment
- Insurance Out-of-Network
- Unable to verify MVA claim information
- Unable to verify W/C claim information
- Other – Medicare/Medicaid

I understand a deposit of \$40 or / Urgent Care copay may be collected and that Xpress Urgent Care may submit my claim for services rendered to my insurance carrier. Based on my policy terms, and available benefits, my insurance carrier may apply these charges towards my deductible, co-insurance, co-payment, or non-covered balances.

If an overpayment is made on my account, I understand that I may request a refund.

- Good Faith Deposit Collected
- Good Faith Deposit Not Collected
- Co-Pay Collected

Reason for Non-collection _____

Insurance Company Name: _____

Signature of Patient/Responsible Party/Legal Representative

Date

Name of Patient/Responsible Party/Legal Representative

Name of Witness