



## **PATIENT FINANCIAL RESPONSIBILITY FORM**

Thank you for choosing Xcel Urgent Care, PLLC ("Xcel Urgent Care") as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you review and sign this Patient Financial Responsibility Form to acknowledge your understanding of our financial policies.

### **1. PATIENT'S FINANCIAL RESPONSIBILITIES**

- You are financially responsible for your treatment and care and for the treatment and care of those under your guardianship.
- You must provide us with your most correct and updated insurance information, and you will be responsible for any charges incurred if the information is incorrect.
- If your insurance plan requires a referral, you must obtain such referral prior to your visit.
- Your insurance plan is a contract between you and your insurance carrier, and it is your responsibility to know what your copay, co-insurance and deductible are. Any determination by Xcel Urgent Care of your copay, co-insurance or deductible is provided to you as a courtesy, and it is only an approximation subject to adjustment after processing of your claim.
- You are responsible for the payment of copays, deductibles, coinsurance, and all other treatment or healthcare services not covered by your insurance plan. If you are uninsured, you are responsible for all treatment and healthcare services provided to you.
- Payment is due at the time of service. Any undisputed amount not timely paid at the time of service may accrue, at Xcel Urgent Care's discretion, late charges at the rate of 1.5% of the outstanding balance per month, from the date such payment was due.

### **2. PATIENT AUTHORIZATIONS**

- Assignment of Insurance Benefits: By my signature below, I hereby authorize assignment of financial benefits directly to Xcel Urgent Care for services rendered as allowable under standard third-party contracts.
- Release of my Records: By my signature below, I hereby authorize Xcel Urgent Care and its associated physicians and staff to release to the necessary insurance companies, third-party payors, governmental agencies, any other entity financially responsible for my medical care, or any other healthcare practitioners required to participate in my care, all medical and other information obtained during the course of my examination and/or treatment, as well as information required for pre-certification, pre-authorization, or referral to other medical providers.
- I understand that any time I inform Xcel Urgent Care that I have no intention of paying any amount due, or any time Xcel Urgent Care reasonably believes that I have no intention of paying any amount due, Xcel Urgent Care may take legal action to collect said amount. In that case, and if I do not prevail in such legal action, I agree to pay Xcel Urgent Care all legal costs and fees incurred as a result of such legal action.

**I have read, understand, and agree to all the above information listed in this Patient Financial Responsibility Form.**

**Patient**

**Patient's Legal Guardian (if applicable)**

\_\_\_\_\_  
Signature (Firma)

\_\_\_\_\_  
Signature (Firma)

\_\_\_\_\_  
Printed Name (Nombre)

\_\_\_\_\_  
Printed Name (Nombre)

\_\_\_\_\_  
Date (Fecha)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date (Fecha)