XCEL PRIMARY CARE

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Xcel Primary Care, PLLC ("Xcel Primary 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 and its Addendum 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 Primary 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 time of service. Any undisputed amount not timely paid at the time of service may accrue, at Xcel Primary 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 the assignment of financial benefits directly to Xcel Primary Care for services rendered as allowable under standard third-party contracts.
- **Release of my Records:** By my signature below, I hereby authorize Xcel Primary 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 Primary Care that I have no intention of paying any amount due, or any time Xcel Primary Care reasonably believes that I have no intention of paying any amount due, Xcel Primary 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 Primary 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

_____
Signature

_____
Printed Name

_____
Date

Patient's Legal Guardian (if applicable)

_____
Signature

_____
Printed Name

_____ _____
Relationship to Patient Date

XCEL
PRIMARY CARE

ADDENDUM TO PATIENT FINANCIAL RESPONSIBILITY FORM

I understand that operating a healthcare facility is costly and that not showing up for an appointment causes financial losses to Xcel Primary Care. Therefore, I agree to the following:

- If I decide to cancel an appointment, I will provide Xcel Primary Care with a notice of cancellation at least 48 hours in advance.
- If I make an appointment less than 48 hours in the future, I will provide Xcel Primary Care with a notice of cancellation at least 24 hours in advance.
- If I make an appointment less than 24 hours in the future, my appointment is non-cancellable unless agreed to in writing by Xcel Primary Care.
- If I do not cancel an appointment according to the terms above and I do not show up for my appointment, I agree to pay a $75 no-show fee to Xcel Primary Care. In furtherance of this goal, I agree to provide Xcel Primary Care with a Credit Card or Debit Card at the time I make an appointment, which would be charged the above $75 fee.
- I further agree that if I request my bank to reverse the charge, Xcel Primary Care can provide the bank with a copy of the signed Patient Financial Responsibility Form and this Addendum as proof of my agreement to be charged the $75 no-show fee.

I UNDERSTAND THAT THIS ADDENDUM IS INCORPORATED INTO THE PATIENT FINANCIAL RESPONSIBILITY FORM THAT I SIGNED ON THIS DATE OR THAT IS ALREADY ON FILE WITH XCEL PRIMARY CARE.

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

Patient

_____
Signature

_____
Printed Name

_____
Date

Patient's Legal Guardian (if applicable)

_____
Signature

_____
Printed Name

_____ _____
Relationship to Patient Date

Revised: 5/30/2025