HealthFirst Primary Care

PATIENT RESPONIBILITIES

- It is the patient's responsibility to know your insurance benefits and policy requirements for office visits and procedures. _____ initial

- It is the patient's responsibility to bring your **current insurance card** and **method of payment** for **each office visit or procedure.** _____ initial

- It is the patient's responsibility to **update** you insurance information, current address and contact information for our records. Failure to do so may result in discontinuing of medical care. _____ initial

- It is the patient's responsibility to keep **follow up** appointments as scheduled. Failure to show up for appointments or procedures can result in **delay** follow up on abnormal lab studies, imaging studies, and biopsy results. It also can result in delay in diagnosis or missing serious conditions including cancer, which can be detrimental to your health. It is your responsibility to reschedule appointments for continuing of care _____ inital

- If you have any questions regarding your care or need any help you can talk to your M.D., or M.A. if for any reason you are still not satisfied make an appointment and have all your questions answered. _____ initial

- Consecutive failure to keep appointments up to 3 instances, and accounts no longer maintained in good faith status may result in termination of provider patient relationship with HFPC.

  _____ Initial

_____

Patient signature

HEALTHFIRST PRIMARY CARE FINANCIAL AGREEMENT AND POLICIES

We verify eligibility and request an insurance card for every visit

Payment policy/insurance submissions

Payment in full is required at the time of service for all past due balances, deductibles amounts that have not been met, non-insured patients and any coverage that could not be verified at the time of service. As a patient/guarantor you are required to pay the co-pay/coinsurance at the time of service. Claims are billed to the insurance carrier as a courtesy; however you are responsible for payment of all charges incurred. All balances not paid by the insurance carrier within 90 days of the date of service will be your responsibility. We will be happy to reimburse you for any payments made by you after your insurance company has paid in full.

PLEASE NOTE: IF YOU HAVE CHANGES TO YOUR INSURANCE INFORMATION, PLEASE NOTIFY OUR OFFICE IMMEDIATELY. HFPC WILL NOT BE RESPONSIBLE FOR TIMELY FILING DENIALS IF WE DO NOT RECEIVE THE CORRECT INSURANCE

____ Initial – I have read and agreed to the above statement

RETURNED CHECKS

IF YOU RECEIVE A STATEMENT IN THE MAIL, YOU MAY PAY BY CHECK

All checks returned for insufficient funds, closed accounts, or any other reason will be subject to a $25.00 service charge. The service charge and the amount of the check must be paid in full within three working days by cash, credit card or certified funds. Thereafter, checks will no longer be accepted for services rendered. Please make arrangements for all future payments to be made by cash, visa, master card or debit card with the visa or master card logo.

____ Initial – I have read and agreed to the above statement

PAST DUE BALANCES

We will require all balances over 90 days from the date of service to be paid in full before further routine services are rendered regardless or wheather or not there is insurance coverage. Future visits will also require payment in full until the issue with the insurance company is resolved. We are willing to assist you in resolving balance and payment issues. Payment arrangements must be made with the billing department, and will not be accepted until our office receives the payment agreement. Balances not paid over 90 days or failure to comply with prior agreements is subject to collection action and dismissal from the practice. If your account is referred to collection, you will be responsible for all attorney's fees and collection expenses.

____ Initial – I have read and agreed to the above statement

No show/cancelled appointments

All appointments require at least a 24-hour prior notification or cancelation. no shows or appointments cancelled with less than 24-hour notice will be subject to the following charges:

Appointment	Charges
1st encounter	Waived
2nd encounter	$10.00
3rd encounter	$25.00

4th encounter will result in the patient being discharged from the practice.

* AHCCCS patients will be reported to their AHCCCS plan after the 2nd encounter as stated above and dismissed from the practice after the 4th encounter as stated above.

____ Initial – I have read and agreed to the above statement

INSURANCE AUTHORIZATION

I authorize HFPC to release any medical or other information to the insurance carrier which may be necessary to process the claims. I authorize my insurance carrier to pay the provider or service. In the event that payment is made to the policy holder, I agree to submit to HFPC immediately.

Signature:_____ Todays Date:_____