



FINANCIAL POLICY

The following is a statement of our financial policy outlining patient and practice financial responsibilities. Please feel free to contact us at (580)357-4200 if you have any questions.

MEDICARE

WellFast Urgent Care Center accepts assignment for Medicare. We will file any secondary insurance claims.

ALL INSURANCE CARRIERS

Claims will be filed with your insurance company. You will be responsible at the time of service for all co-pays, co-insurance, deductibles and services not covered by your plan. Financial responsibility for services rendered rest with the patient regardless of any insurance coverage.

Although we will do everything possible to facilitate reimbursement from your insurance company, we cannot guarantee payment of your claim. We file insurance as a courtesy. Insurance follow-up is the responsibility of the patient. If the claim becomes the patient's responsibility, the claim must be paid within 30 days.

SELF PAY PATIENTS

Full payment is due at the time of service. We accept cash, checks, Visa, MasterCard and Discover.

CHANGE OF INSURANCE

IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH ANY INSURANCE CHANGES. Claims denied due to "untimely filing" will be the patient's responsibility, if we were not initially provided with the correct billing information, which resulted in late submission.

MEDICALLY NECESSARY SERVICES

The insurance company may deny some services as not medically necessary. The patient is responsible for all billable services.

ACCOUNT BALANCES

Any patient balances remaining after insurance payment must be fully paid within 30 days. For your convenience, payments may be made online by visiting our website www.wellfasturgentcare.com. Regardless of any pending claims, if there is an open balance above \$25.00, two statement will be sent to you followed by a pre-collection letter. If payment is not received, your account will be sent to collections. All patients with outstanding balances will not be seen unless account is paid in full.

COLLECTIONS AND NSF CHECKS

Delinquent accounts will be forwarded to our collection agency. A collection fee of 25% of the account balance due will be added to the unpaid balance to recover our costs for collection. In the event litigation is necessary, you will be liable for court costs and attorney fees.

A \$30.00 fee will be charged for any NSF checks. Returned checks will be turned over to the Comanche County District Attorney's office.



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MEDICAL RECORDS

Your medical records will be held in the strictest confidence. If you request a copy of your records to be sent to another physician or to yourself, a written authorization will be required. Our medical records department will notify you with the processing fees and any additional costs that may incur. Only the records requested will be forwarded. Should you bring in another physician’s records to us, you may want to consider keeping a copy for yourself.

I hereby give my consent for WellFast Urgent Care Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations.

I expressly consent and agree that, in order to discuss or service your accounts(s) (the “Accounts”) or to collect amounts you may owe, WellFast Urgent Care Center, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, “We”) may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

By signing below, I acknowledge that I have read and understand the information presented above and wish to receive diagnostic and treatment services from WellFast Urgent Care Center. I agree to be fully responsible for any and all charges for services rendered and not covered by my insurance plan.

A photocopy of this agreement shall be as valid as the original.

IMPORTANT: Read all sections before signing. I acknowledge that I have received, read, and understood this financial policy notice.

X _____
PRINT Patient Name

Patient / Authorized Person Signature

X _____
PRINT Authorized Person Name / Relationship

X _____
Date