24 HR Lifeline MD
Urgent Care and Family Medicine
12640 Twelve Mile Rd, Warren, MI 48093
www.24hrurgentcare.com
586-751-2020 Main
586-745-1756 Fax

FINANCIAL POLICY & RESPONSIBILITY AGREEMENT

Thank you for choosing our providers for your health care needs. If you have medical insurance we want to assist you in receiving your maximum allowed benefits. In order to achieve this goal, we request you thoroughly review and sign the terms of our payment policy. There is a separate “No Surprise Billing Form” which will also require signature attestation.

1. Payment is due at the time of service. This includes all co-pays and deductibles required by your insurance plan. Co-pays that are not paid at the time of patient visit will incur an additional $15.00 administrative fee pending payment for date of service.

2. While the filing of insurance claims is a service that we provide to our patients, all charges are your responsibility from the date of service. Any remaining balance of non-covered benefits will be the sole responsibility of patient. It is the patient responsibility to make arrangements for prompt payment as required.

3. Patient account balances must be paid within 30 days. A rebilling charge of $10.00 is added each month to unpaid balances over 30 days old.

4. Accounts without payment for greater than 90 days will be transferred to collection agency. Any costs associated with the agency will be your responsibility in addition to the original delinquent balance.

5. Returned check fee of $75.00 will be incurred to patient.

6. Appointments that cannot be kept must be cancelled 24 hours before the appointment. Those that are not cancelled within the requested timeframe, or are missed altogether, may be charged the rate of an office visit.

We realize that temporary financial problems may occasionally affect timely payment of your account. If such problems arise, please let us know immediately and we will be happy to assist you in arranging a suitable payment plan.

I, (print name)____, have read the Financial Policy of 24HR Lifeline MD and I understand and agree to all terms of the policy as stated above.

____ ____________________________
Signature of Patient, Guardian or Responsible Party Date

Patient’s name if other than above ____
Please print