



# THE MEDICAL CORNER

## Financial Responsibility and Payment Agreement

The Medical Corner is committed to providing you with the best possible medical care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

### General Terms:

As a patient at the The Medical Corner, you are responsible for payment of all services provided to you in accordance with our established charges.

Payment of services is due at the time services are rendered by The Medical Corner. You may pay for your services by cash, check, MasterCard, Visa, American Express or Discover Cards. For those patients covered under a medical insurance plan we will collect an estimated co-payment from you after each visit. You must stop by our front desk after services are received to pay your estimated co-payment. If you have no medical insurance we require the full amount for services that were rendered.

### Insurance Claim Processing:

As a service to our patients we are happy to help you process your insurance claim-form for reimbursement of the services rendered. In order for this process to go smoothly we ask that you provide us with the appropriate information (carrier name, carrier address, member number, group number, policy number and any other information that may be necessary to file your claim). If your information changes we ask that you notify us as soon as possible so that we may update your information and expedite the claims filing process. In filing your claim The Medical Corner is accepting assignment of all insurance benefits owed for your date of service.

We must emphasize that we are medical care providers, our relationship is with you, our patient, and not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

### Assignment of Proceeds from Third-Party Liability Claims:

If you are invoiced in any claim or litigation involving third-party liability for injuries sustained in an accident, you will agree to assign to The Medical Corner all proceeds from no-fault insurance and/or other actions against the third party until such time as the outstanding balance on your account has been paid in full. Under circumstances where litigation is pending, you will be held personally responsible for settling your account within the limits of our stated credit policy.

### Work Related Injuries:

In you are being treated for a work-related injury, you agree to assign the proceeds of any workers' compensation claims (designated for payment of medical costs incurred in the treatment of the injury) to The Medical Corner.

If your workers' compensation claim is denied by the workers' compensation insurance carrier or the State Department of Labor and Industrial Relations, you will be fully responsible for these expenses. The charges will be due and payable at the time the claim is denied. The Medical Corner will collect on all amounts which remain outstanding following a determination on the case.

Patients with work-related injuries are responsible for cooperating with The Medical Corner in the delivery of any documents necessary to validate the workers' compensation claim.

### Monthly Billing:

The Medical Corner bills patients once each month. There will be a \$5.00 additional fee for each patient that receives a bill after the initial statement. The amount due on your statement is due upon receipt. If the amount due is not paid in full, any unpaid portion of charges outstanding will be considered delinquent and subsequently charged a late fee of \$5.00 in addition to the monthly billing fee. The Medical Corner will take immediate steps to collect on all delinquent amounts. If you have a delinquent balance, we reserve the right to refuse further treatment at The Medical Corner.

### Collection Fees:

Returned checks are subject to a fee of \$25.00. A billing charge of \$5.00 will be charged for each statement a patient receives after the initial one. For balances older than 30 days The Medical Corner will impose a collection fee and interest charge of 1.5% per month on the unpaid balance in addition to a late fee charge of \$5.00 for all payments made on outstanding balances after the stated due date.

You are responsible for all related expenses incurred in the collection of delinquent amounts on your account. These may include, but are not limited to attorney's fees and/or other costs which The Medical Corner considers necessary in order to collect the amount due.

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**THE MEDICAL CORNER**  
**Financial Responsibility and Payment Agreement**  
**Continued**

**Financial Arrangements:**

We realize that temporary financial problems may affect timely payment of your account. If such a problem arises, we ask that you discuss a Financial Budget Arrangement with our Billing Coordinator.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.

**Statement of Understanding:**

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered as well as any late, collection, or monthly billing fees as stated. I have read all the information above and understand and agree to make an estimated co-payment or payment in full after services are rendered. I further agree to notify The Medical Corner of any changes to my insurance coverage so that filing of my claim is expedited. I have received a copy of this agreement.

\_\_\_\_\_  
*Patient's Signature*  
*(or signature of Patient's Parent or Legal Guardian)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Print Name*

**Assignment of Insurance Benefits:**

I understand it is my responsibility to fulfil the specific requirements of my medical insurance carrier(s) to ensure coverage for all eligible services. I hereby authorize The Medical Corner, dba Acute Care Medical Services, Inc. to 1) submit claims directly to my insurance carrier(s); 2) make direct billing inquiries to my insurance carrier(s); 3) accept payment from such carrier(s); and/or 4) assign payment(s) to any portion of my clinic/hospital bill

**Medicare & Champus Long Term Authorization:**

I request the payment of authorized Medicare Benefits be made either to me or on my behalf for any services furnished to me by The Medical Corner, dba Acute Care Medical Services, Inc. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for rendered services.

\_\_\_\_\_  
*Patient's Signature*  
*(or signature of Patient's Parent or Legal Guardian)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Print Name*