FINANCIAL POLICY

I have requested medical services from Surf Pediatrics and Medicine, PC (doing business as Surf Urgent Care) on behalf of myself and/or my dependents and understand that by making this request I become fully financially responsible for any and all charges incurred in the course of the treatment. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. Our financial policy is listed below:

1. **Co-payments** are **due at the time of service** for every visit with a provider;

2. **Self-pay** patients are expected to pay for services in **FULL** at the time of the visit;

3. Surf Urgent Care is part of Surf Pediatrics and Medicine, therefore we participate with the same insurances accepted by our primary care division. **We bill insurance as primary care we DO NOT bill as Urgent Care.**

4. If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement; It is the patient's responsibility to determine if we are in or out of network with their insurance. If we agree to file for you and we end up out of network you will be responsible for the full bill.

5. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within **30** days from the initial bill sent;

6. If previous arrangements have ***not*** been made with our finance office, any balance outstanding longer than 90 days will be considered past due and forwarded to a collection agency;

7. If you participate with a high-deductible health plan, we require your balances be paid in full within **30** days from the initial bill sent or you may request to place a credit or HSA card on file;

8. We accept cash, checks, Visa, and MasterCard credit and debit.

9. A $20 fee will be charged for any checks returned for insufficient funds and we will no longer be able to accept any checks.

10. **Please let us know how you would like your statements sent to you: Please complete which your prefer:**

Mailing Address:_____

Email address:_____

Patient Name: _____ DOB:_____

Parent/Guardian Name:_____ Relationship:_____

_____

Signature: Date: