AllCare
Primary Care & Walk-ins

FINANCIAL POLICY

Patient's Name:_____ Date of Birth:_____

We are committed to providing you with the best possible care, and will be pleased to discuss our professional fees with you. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, our Financial Policy or your responsibility.

All patients must complete our patient form before seeing the practitioner. In addition to paying in full for your appointment, we will need a copy of your driver's license. It is important you understand that you are responsible for all charges that may occur during your visit. If you insurance company denies the claim, you will be responsible for the entire bill. However, we do offer a payment plan for our follow-up visits; this plan can **NOT** apply towards your first time visit to our clinic. You are ultimately responsible for the timely payment of your account. The cost of the new patient office visit is dependent on the complexity of the visit. The cost of a new patient office visit does not include the cost of any diagnostic testing deemed necessary by the Practitioner reviewing your case. If you have concerns regarding the cost of additional testing that may occur, please express this concern to our staff prior to the visit and they will provide you with all costs involved in procedures.

DIAGNOSTIC TESTING (X-RAY AND EKG)

Although our facility is equipped to perform limited x-rays, if it is necessary for us to order x-rays from an outside facility, you will be billed directly by the x-ray facility. You are responsible for payment of that bill.

LABS

If labs are required during office visits there will be a drawing fee and a handling fee, and a separate charge will come from the Lab Company. We do not collect charges for the following tests, for they are performed in our facility, which include Urine Dips, Pregnancy Tests, Glucose Testing, Strep Testing, Pap Smears and Blood Occult. If you have concerns of lab fees for all other testing that needs to be sent to our Lab Company, please express with concern to the AllCare staff and we can provide this information to you. You are responsible for payment of that bill.

FORM OF PAYMENT INFORMATION - THIS AREA MUST BE COMPLETED IN ITS ENTIRETY.

☐ Cash – Patients who chose to pay in cash must pay the entire cost of the visit at the time the visit is completed. The office does not accept checks for payment. Any cost estimate given prior to the visit is an approximation. The cost of a visit cannot be precisely determined until the completion of the visit.

All patients must include one of the following prior to being seen:

☐ Visa / Debit Account #:_____ CVV:_____ Exp.Date:_____

☐ MasterCard / Debit Account #:_____ CVV:_____ Exp.Date:_____

☐ Amex / Discover Account #:_____CVV:_____ Exp.Date:_____

Print Form

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Patient's Name:_____ Date of Birth:_____

Patient hereby acknowledges and agrees that AllCare is authorized to charge patient's account as listed above for any unreimbursed charges based upon their agreement with any payor of any status. Patients will be sent statements of any unreimbursed charges. If payment is not received, patient understands that patient was informed of the precise amount of any unreimbursed charge in a statement, following submission of the charge to Patient's applicable payor, but Patient expressly agrees that AllCare is authorized to bill Patient's listed account for charges relating to Patient's care.

In the event that AllCare is required to submit this matter to collection, the patient will be responsible for a processing fee equivalent to thirty-five percent (35%) of the outstanding charges.

We find that communication with our patients regarding our financial policy assists us in providing the best service to you. If you have special needs, bring them to our attention early. We are here to help you.

_____ _____
PATIENT NAME DATE

_____ _____
SIGNATURE OF RESPONSIBLE PARTY DATE

ALLCARE 6401 East Thomas Road, Ste 103, Scottsdale, AZ 85251 T: 480-941-4400 F: 480-941-1100
www.allcaremedicine.com