Wise Family Practice
Urgent Care

Thank you for choosing Wise Family Practice Urgent Care Center as your primary or urgent care provider. We are committed to providing you with quality and affordable health care. Please read the following payment policy, ask any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is REQUIRED at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full will be REQUIRED until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co- Payment and Deductibles:** All co-payments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company.
3. **Non-Covered Services:** Please be aware that some, and sometimes all, of the services you receive may be non-covered or not considered medically necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.
4. **Proof of Insurance:** All patients must complete our patient information forms before seeing the provider. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in timely manner, you may be responsible for the balance of a claim.
5. **Claim Submission:** We will submit your claims and assist you in any reasonable way we can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and you insurance company; we are not party to that contract.
6. **Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive the maximum benefits. If your insurance company does not pay our claim the balance may be billed to you.
7. **Non- Payment:** If your account is over 90 days past due, your will receive a letter stating that you have 20 days to pay your account in full. Partial payments will be accepted if negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Our practice is committed to provide the best treatment to our patients. Our prices are representative of the reasonable and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Patient Signature: Date: