Payment Policy:

Insurance: We Participate in most health insurance plans, including Medicare. If you are not insured by a plan we do business with or are not insured, payment in full is expected 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 for each visit is 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. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract. If any disputes/disagreements between your insurance plan and you regarding if and when you were/are covered should arise, payment in full by you will be required regardless of your dispute/disagreement.

Medicare Part B Patients: We participate with Medicare Part B. Medicare does not cover all healthcare services. In the event a service is needed that Medicare Part B will/does not cover, you will be advised prior to providing the service that is not covered by Medicare and provided with an Advanced Beneficiary Notice (ABN). This document is required by Medicare and will explain what the service is that is not covered and why it is not covered by Medicare, allowing you to make an informed decision on whether or not you still require the service in question. By signing this form, you hereby authorize WeCare Medical Associates, LLC to release information required by the Social Security Administration or it's intermediaries for purposes of medical claims. Additionally, you hereby agree and assign the benefits payable for covered services to WeCare Medical Associates, LLC and/or its healthcare providers.

Co-payments and Deductibles: All co-payments and deductibles must be paid at the time of service. Co-payment is for specialist services. This arrangement is part of your contract with your insurance carrier and our contract with your insurance carrier. Failure on our part to collect co-payments and deductibles from patients can be considered fraud and is a violation of our contract and your responsibility with your insurance plan. Please help us in upholding both of our contractual obligations by paying your co-payments at the time of service.

Non-Covered Services: Please be aware that some or perhaps all of the services you receive may be non-covered or not considered reasonably necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. An example of some items that may not be covered is medical supplies and equipment and copies of your medical records.

Proof of Insurance: All patients must fully complete our patient information form before seeing a healthcare provider. We must obtain a copy of photo identification and a current, valid health insurance card that provides coverage for the date(s) for which you are provided a service by us.

Claims Submissions: If you have an insurance plan with which we participate with, we will submit your claims to the insurance plan and assist you in any way we reasonably can to help get your claims paid. Your insurance plan 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 your insurance company; we are not a party to that contract.**

Payment Arrangements: Payment arrangements/Payment plans can only be made at the time services are provided.

Nonpayment: If any balance due by you is over 90 days past due, you will receive a statement stating that this is your final notice and that payment in full must be received immediately. If said balance remains unpaid, we may refer your account to a collection agency.

Collection Agency: In the event an unpaid balance by you is referred to a collection agency, you hereby agree to pay 18% interest per annum, plus attorneys fees which are hereby stipulated to be 33 1/3% of the outstanding balance, plus court costs in addition to the outstanding balance whether or not suit is filed.

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____

PRINTED NAME: _____ **DATE:** _____