NORTHEAST HEALTH DISTRICT - FINANCIAL POLICY

☐ I do ***not*** have insurance

☐ I do have insurance

CLIENT WITH NO INSURANCE

I acknowledge that as a self-pay client I am responsible for the cost of the services received, if applicable, and am expected to pay at the time the service is rendered.

CLIENT WITH INSURANCE

I acknowledge that I am required to provide my insurance card(s) at every visit. This ensures that the information collected by this County Health Department is correct, and that my plan is current and is a participating plan for this provider. Providing out of date cards, cards with incorrect information, or the wrong insurance cards may cause unnecessary delays in the payment of my claim, and the balance ultimately may become my full financial responsibility. If I am unable to provide all my insurance information in full, I will be charged as a self-pay client and I can submit the receipt to the insurance company for possible reimbursement.

I acknowledge that the agreement of the insurance carrier to pay for medical care is a contract between myself and my insurance carrier. I should direct any questions and/or complaints regarding my coverage to my insurance carrier. I should contact my insurance carrier in advance to determine whether a service is covered by my plan if I am unsure which services are covered.

I acknowledge that it is my responsibility to understand the medical benefits covered by my insurance plan. There may be limitations and exclusions to my coverage. My portion is set by the insurance company. If I do not wish to have claims submitted to my insurance carrier, I may choose to self-pay for the services at the time of the visit.

Non-Covered Services Are My Responsibility

I acknowledge that when a service is not covered by my insurance policy, I am responsible for the cost of that service. It is my responsibility to know which services are covered by my insurance policy.

Payments

I acknowledge that all office co-pays are due at the time of service. This is an insurance company policy. I am responsible for any co-insurance, deductibles, and any other non-covered billable services. Balances are due upon receipt of statement and may be issued after the insurance carrier pays its portion of the bill.

Labs Processed by an Outside Facility

I acknowledge that my lab work may be sent to an outside lab facility for processing (Quest or LabCorp). I may be billed separately by the outside lab facility, and co-payments, deductibles or co-insurance may apply. My health insurance carrier will determine coverage and payment, as well as the amount for which I am responsible; therefore, I may also receive a separate invoice from the lab.

Insurance Filing and the Law

Federal law requires the Health Department to accurately submit claims to insurance carriers and to report the exact service(s) performed and the exact reason(s) those services were performed. Our Health Department is bound by these laws and will submit claims to all insurance carriers in this manner. The Health Department is not allowed to change this information just so an insurance carrier will pay the claim. It is your responsibility to understand your insurance plan.

Client Last Name: _____ Client First Name: _____

Client Representative Information *(if signing for Client)*:

Last Name:_____ First Name: _____ Birthdate: _____

Relationship to Client: _____ Race:_____ Sex:_____

Client / Representative Signature: _____ Date:_____