



***Patient Financial Responsibility Form***

Thank you for choosing Makana North Shore Urgent Care for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient’s guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
  - Charge for returned check - \$ \_30.00\_\_
- You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to pursue the claim for workers’ compensation or (2) it is determined by the Workers’ Compensation Board that the illness or condition which required treatment was not a result of compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers’ Compensation §32 in which you waive your right to medical benefits from the workers’ compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider’s fees for services rendered.
- By my signature below, I hereby authorize assignment of financial benefits directly to Makana North Shore Urgent Care and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Name \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_