FINANCIAL AND PAYMENT POLICY

Thank you for choosing the Neighborhood Clinic. We are dedicated to providing the highest quality care that is affordable to our patients. This financial policy is an agreement between Neighborhood Clinic and you, the patient or responsible party.

Patient Responsibilities: For those patients who do have insurance, any payment that your insurance requires (deductible, co-pay, co-insurance, etc.) is due at the time of service. You must provide us with a current insurance card and billing information at each visit. It is your responsibility to know your insurance policy and benefits and be familiar with your coverage. This includes verifying whether or not our providers are in/out of network with your specific policy. You are responsible for all unpaid balances. We will bill your insurance as a courtesy and make every effort to ensure claims are submitted correctly and promptly.

For those patients who do not have insurance, we are sensitive to your individual financial constraints. We do offer a discount if full payment if made at the time of service. Otherwise, 50% is due at time of service and then it is your responsibility to contact our billing agency to set up a payment plan for the remainder of the balance.

I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, co-insurance, co-pay or any service(s) deemed "non-covered" by my insurance carrier at the time service was rendered. Failure to pay outstanding balances within 90 days of notification of the amount due, and without any action on your part to remedy the situation, will result in your account being referred to a collection agency. If your balance remains unpaid, you and your immediate family members may be discharged from this practice.

Past Due Balances: Patients who have a previous collection agency balance and wish to receive services are required to pay any collections balances in full as well as any co-pay or co-insurance at the time of service.

By signing this form you are acknowledging that you understand and agree to our financial and payment policies.

_____ _____

Signature of Patient or Legal Representative Date

_____

Printed Name

(Rev 09/15)

AUTHORIZATION TO VIEW RX HISTORY FROM EXTERNAL SOURCE

By signing this form you are authorizing Neighborhood Clinic to view your available prescription history from an external source. Authorization to view your prescription history allows us to obtain past prescription information from pharmacies. This will aid our providers in giving you the most informed medical care available.

_____ _____

Signature of Patient or Legal Representative Date

PRESCRIPTION REFILL POLICY

We do require office visits and/or lab work on a regular basis for all of our patients taking prescription medication. This interval will vary depending on the type of medication prescribed.

Please contact your pharmacy if you would like to request a refill. The pharmacy will then contact our office for authorization on your behalf – no need to contact our office directly.

Please allow 24-48 hours for refill authorization.

Medication for acute problems will require an office visit to ensure that a correct diagnosis is made and that an appropriate medication is prescribed.

By signing this form you are acknowledging that you understand and agree to our prescription refill policy.

_____ _____

Signature of Patient or Legal Representative Date

ACKNOWLEDGMENT/ REVIEW OF NOTICE OF PRIVACY PRACTICES

By signing this form you are acknowledging that you have reviewed and understand our Notice of Privacy Practices. This notice describes how Neighborhood Clinic may use and disclose your protected health information and rights you have regarding your protected health information.

_____ _____

Signature of Patient or Legal Representative Date

(Rev 09/15)