Patient Name:

Date of Birth:

Patient ID:
Visit ID:
Date of Visit:

Billing Policy

Effective 07/01/2017

In consideration of the services to be provided by Rural Urgent Care LLC/MainStreet Family Urgent Care/ KidsStreet Urgent Care and its physicians, providers, and Independent Physician Contractors, the undersigned jointly and severally, agree to pay all charges, deductibles, co-payments, and/or co-insurance amounts determined not paid or allowable by health insurance payors. Certain routine services and procedures, which are determined as necessary by the treating physician/provider, may not be covered by Medicare, Champus, Blue Cross and Blue Shield, and other third party payors. I/we agree to pay these non-covered services and/or procedures if ordered and performed by the treating physician/provider or Rural Urgent Care LLC/MainStreet Family Urgent Care/KidsStreet Urgent Care. I/we agree to make payments according Rural Urgent Care LLC/MainStreet Family Urgent Care/KidsStreet Urgent Care credit terms. In the event I/we should default in payment of any of the above charges then I/we agree to pay all reasonable costs of collection, including a reasonable attorney's fee as might be allowed by law, whether the account shall be referred to a collection agency or an attorney.

ASSIGNMENT OF BENEFITS:

The undersigned assign payment of authorized insurance benefits otherwise payable to the policyholder, including Medicare and Champus benefits, directly to Rural Urgent Care LLC/MainStreet Family Urgent Care/ KidsStreet Urgent Care, or its authorized representatives who provide services. I certify that all information is correct which has been given to apply to payment under Medicare, Champus, managed care, and Blue Cross and Blue Shield, and other third party programs.

AUTHORIZATION FOR RELEASE OF INFORMATION:

The undersigned authorize Rural Urgent Care LLC/MainStreet Family Urgent Care/KidsStreet Urgent Care and its treating physicians/providers, to furnish any medical and billing information about this account, including but not limited to the following:

INSURANCE BILLING -- information requested by the insurance company, Medicare, Champus or other third party payors to support the claim submitted for payment of charges applicable to this account.

MEDICAL NECESSITY AND APPROPRIATENESS OF SERVICES -- Information requested by any utilization and/or Peer Review Organization associated with the insurer(s) to evaluate the medical necessity and appropriateness of services of the account or to determine the benefits for related services.

This release allows disclosure about the treatment, diagnostic testing, or other medical information including psychiatric, alcohol, HIV, drug abuse, cancer registry treatment and follow-up and/or other confidential information. The recipients are prohibited from any re-disclosure of this information. The undersigned has the right to subsequently revoke this release. The revocation shall not pertain to information previously released. Information requested in good faith by any health care facility or physician for facilitating continuing care and treatment is authorized.

MainStreet FAMILY URGENT CARE

KiDS Street URGENT CARE

Patient ID:
Visit ID:
Date of Visit:

PAYMENT OPTONS:

Prior to receiving service, all patients must pay their copay. For any remaining balance, patients may select one of two options:

☐ I elect to pay my copay today and I authorize Rural Urgent Care LLC / MainStreet Family Urgent Care/KidsStreet Urgent Care to keep my signature on file and to charge my Visa, MasterCard, Discover or American Express indicated below:

☐ **Single/One-Time Charge** or ☐ **Recurring Charges**

☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **Amex**

Last Four of Card Number:_____ **Card Expiration Date**: _____

I authorize Rural Urgent Care LLC / MainStreet Family Urgent Care/KidsStreet Urgent Care to process my credit card for any balance not paid by insurance up to a limit of $125. I understand that if my balance is $5 or less I will not receive notification prior to my card being processed. I authorize Rural Urgent Care LLC to transfer any remaining balance to my responsibility 120 days from the date of service. I understand this form is valid unless I cancel this authorization by written notice. If I choose to cancel this form, I assume responsibility for paying my charges in full.

_____
Patient Name

_____
Cardholder Name

_____
Cardholder Billing Address

_____
City State Zip

☐ I elect to make a Patient Deposit of $_____.

For balances greater than $5.00, patients will receive one written statement at the mailing address they provide.

Any balance unpaid 30 days after your insurance processes or 120 days from the date of service, whichever occurs first, may be sent to a collections agency at any time.

All “Self-Pay” or “Time-of-Service” patient balances are due at the time of service.

Any overpayment will be held as credit on the account unless a refund is requested in writing by the patient.

All returned checks or charges disputed with merchant services will result in a fee of $30.00 to the guarantor.

By providing my electronic signature below, I acknowledge that I have read and accept Rural Urgent Care LLC/ MainStreet Family Urgent Care/KidsStreet Urgent Care's Notice of Privacy Practices and Billing Policy. I authorize them to process my payment as indicated above.

X_____ _____

Signature Date