TruCare Medical Center
FINANCIAL & OFFICE POLICIES

Dear Patient,

Thank you for choosing us as your health care provider. Our main concern is that you receive the proper and optimal treatment needed to restore your health. Therefore, if you have any questions or concerns about our policies, please do not hesitate to ask the staff for clarification. Please read and sign our financial policy as well as complete our patient information form prior to seeing the doctor.

TruCare Medical Center provides care to patients without discrimination based on age, sex, race, color, religion, national origin, disability or type of illness or condition.

CASH PAYMENTS: Payment for service is due at the time of service. We accept cash, checks, debit cards and most major credit cards for your convenience. Check amounts may be deducted immediately from your account using ACH processing.

RETURNED CHECKS: These are subject to a **$30.00** fee, and you may be asked to make future payments by cash, credit card or money order. _____ Initial

INSURED PATIENTS: Copays and deductibles are due at the time of service. These payments cannot be waived as they are part of the contract that you have signed with your insurance company. We bill your insurance as a courtesy to you. In the event that your insurance company does not pay your balance within 30 days, we ask that you contact your carrier to speed things up. In certain cases, you may be required to provide more information to expedite payment. Please do so promptly, or you will be billed for the full amount. _____ Initial

ANNUAL HEALTH CHECK: Periodic preventative health checks may be covered under your insurance policy under the new ACA; however it is your responsibility to check with your insurance provider. Immunizations must be covered by your insurance to be given here or you will be responsible for the cost. _____ Initial

MISSED APPOINTMENTS: We reserve the right to charge a **$25.00** fee for "No Shows". The time has been reserved exclusively for you and no-shows are disruptive to our practice. We ask that you give us adequate notice to allow us to schedule another patient if you cannot make your appointment. Persistent no-shows may be asked to walk in and wait to see the doctor, and if this continues to be a problem, you may be dismissed from the practice.
. _____ Initial

SPECIAL FORMS: We charge a **$30.00** fee for all special forms to be filled by the physicians or TruCare Medical staff and **$10** for letters. We also ask that you allow **at least** 48 hours for the completion of such forms/letters. Medical records are copied at a rate of 60 cents per page after a release has been signed. _____Initial

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PRESCRIPTIONS: Prescriptions, other than narcotics, are called, faxed to or sent electronically to your designated pharmacy. Lost or stolen prescriptions will **not** be refilled before the next due date even with a police report. You are ultimately responsible for keeping them safe.

Please give yourself enough time to get refills processed by requesting refills at least a week BEFORE you run out of your medication. Due to the high volume of requests, please allow up to 72 hours for requests to be completed.

The doctor may request that you make a follow up visit before filling a repeat prescription. **Narcotics are NOT filled by phone or fax and no refills are given.** If you have been seen in a while, you may have to schedule an appointment to review your health issues.

HIPAA (Privacy):

Every effort is made to respect and keep your information private. To this end, we do not give out detailed health information over the phone. This includes lab and other test results as we cannot verify who we may be speaking with. We ask that you schedule an appointment to review results with the physician as he can interpret them accurately for you. You may ask for a copy of your labs or get it directly from the lab portal. (You will have to sign up with the lab for this).

I/WE DO HEREBY AGREE THAT ALL INVOICES PAST DUE BY SIXTY (60) DAYS MAY BE CHARGED INTEREST AT THE CONTRACTUAL RATE OF 5 PERCENT (5%) PER MONTH. I/WE UNDERSTAND THAT IF PAYMENT IS NOT MADE IN A TIMELY MANNER, MY ACCOUNT WILL BE TURNED OVER TO A COLLECTION AGENCY.
I/WE HEREBY AGREE TO PAY ALL COLLECTION AND COURT COSTS, ATTORNEY AND SERVICE FEES WHICH MAY ACCRUE IN PURSUIT OF YOUR BALANCE OWED.

I have read the above policies and agree to comply with them. By signing this, I am giving you the authority to enforce any of the policies as they apply to me.

Patient's Signature: _____ Date: _____

Assignment of Benefits:

I hereby guarantee payment of all charges incurred at TruCare Medical Center. I hereby assign and direct to pay any and all benefits for medical services under this claim, including any hospital stays that are covered by the physicians from TruCare Medical Center. I hereby authorize the release of all medical information requested by the insurance company(ies) with respect to the above assignment.

Patient's Signature: _____ Date: _____
(Parent / Guardian, if patient is a minor)

Again, thank you for choosing Dr. Addo-OQuaye and TruCare Medical as your primary care provider (PCP). We appreciate your trust in us and we appreciate the opportunity to serve you and your family.