DMC PRIMARY CARE
Derry Medical Center

Patient Financial Agreement

DMC Primary Care is committed to providing patients with information regarding their coverage and financial responsibilities. In consideration of services provided by DMC Primary Care, the Patient or undersigned representative acting on behalf of the Patient agrees to the following:

INDIVIDUAL FINANCIAL RESPONSIBILITY- I understand that I am financially responsible to pay the amount of all charges incurred for services and procedures received at DMC- Primary Care and agree to the following:

Proof of Insurance- I understand that it is my responsibility to provide DMC- Primary Care with a copy of my current insurance card(s). I understand it is my responsibility to update DMC-Primary Care as soon as possible regarding any changes to my insurance(s).

Non-covered Services- I understand that I if I am provided a service that is not covered by my healthcare insurance plan, that I am responsible for any remaining balances. If feasible, a separate signed waiver may be requested by DMC Primary Care.

Uninsured- If I do not have insurance, I will be considered a Private/Self-Pay patient and will be responsible for payment at the time of service, as well as any remaining balances billed to me after services are rendered.

Co-payments and Balances After Insurance- I understand insurance co-payments are due at the time of visit. I further agree to pay any balances arising for deductibles and/or co-insurance.

Outside Laboratory- I understand services sent to an outside laboratory are billed to my insurance or to me by the lab and I will receive a separate invoice from the laboratory.

Patient Credits- I understand any patient credits will be applied to any of my other outstanding patient balances owed for any other DMC-Primary Care or Derry Imaging services received, prior to any refund being issued.

Consent to receive text and email notifications- I consent to receiving electronic notifications via text message and emails regarding outstanding balances and financial responsibilities, and understand that I have the right to opt out of receiving those.

Discharge- I understand that failure to meet the financial obligations of my care at DMC-Primary Care may result in my inability to obtain future care until my obligations are met.

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Payment to DMC-Primary Care may be made to in the form of cash, check, or debit/credit card. In the event I receive payment directly from my health insurance carrier, I agree to endorse or forward payment due for services to me by DMC-Primary Care.

Assignment of Insurance or Health Plan Benefits- I acknowledge the assignment and authorization for direct payment to DMC for all insurance and health plan benefits and settlements whether medical or liability insurance including but not limited to, the proceeds of any settlement or judgement of any third party claims as payment for any and all services performed at a DMC-Primary Care facility.

Assignment of Medicare Benefits- I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I request the at the payment of authorized benefits made on my behalf to DMC-Primary Care and all Healthcare Professionals rendering care and/or treatment to me and authorize DMC- Primary Care and Healthcare Professionals to submit claims to Medicare for payment if applicable. I authorize DMC-Primary Care to release to Medicare and its agents any information needed to determine these benefits for related services.

Filing of Third-Party Claims- I acknowledge that upon proof of coverage DMC-Primary Care will submit a claim for payment of insurance benefits and accept payment from third party payors to be credited to my account as they are received. I agree that the filing of insurance claims is performed as a service and in no way relieves me of the obligation to pay in full.

Authorization to Release Information- I authorize DMC-Primary Care to release to insurer, governmental agencies or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider(s).

Validity of Form- I acknowledge that a copy or an electronic version of this document may be used in place of and is as valid as the original. I confirm that I have read, understood, and accepted the terms of this document and I am the patient or the patient's legal representative or am duly authorized by the patient's general agent to execute and accept its terms.

Patient/Legal Representative: Date and Time: