DMC PRIMARY CARE
Derry Medical Center

PATIENT FINANCIAL AGREEMENT

Patient Name (First and Last): _______________________________ Date of Birth: ________________

DMC Primary Care is committed to providing patients with information regarding their insurance coverage and financial responsibilities. In consideration of the services provided by DMC Primary Care, the undersigned patient or patient representative agrees to the statements listed below.

INDIVIDUAL FINANCIAL RESPONSIBILITY: I understand that I am financially responsible to pay for 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 health 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 insurance plan, I am responsible for any remaining balances. There may be circumstances when a separate signed waiver may be requested by DMC Primary Care.

Uninsured: I understand that 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 the visit. I further agree to pay any balances related to deductibles and/or co-insurance.

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

Patient Credits: I understand that 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 email, regarding outstanding balances and financial responsibilities. I understand that I have the right to opt out of receiving electronic notification at any time.

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.

Payment for Services: I understand that 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 to DMC Primary Care for services provided to me by DMC Primary Care.

Assignment of Insurance or Health Plan Benefits: I acknowledge the assignment and authorization for direct payment to DMC Primary Care 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 DMC Primary Care.

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 payment of authorized benefits be made on my behalf to DMC Primary Care and its healthcare professionals rendering care and/or treatment to me and authorize DMC Primary Care 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 by DMC Primary Care 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 insurers, governmental agencies or any other entity financially responsible for my medical care, all information (including diagnoses and records of any treatment or examination rendered), in order to substantiate payment for such medical services, or as required for pre-certification, 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, duly authorized to execute and accept its terms.

____	______________________
Signature of Patient/Legal Representative:	Date and Time:
____	______________________
Print Name of Legal Representative (if applicable)	Relationship to Patient