

Insurance Information

Patient's Name: _____ Today's Date: _____

First Middle Last

[Primary Insurance Information]

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Insured's Name: _____ Insured's Date of Birth _____

Insured's SSN: _____ Group Number: _____

Policy ID Number: _____

Our office will file to our contracted insurances for all reimbursable services. We will courtesy file **one time**, to your non-contracted primary insurance carrier, at our discretion. We will not file secondary insurances. Please remember that you are responsible for all deductible, copay, and non-covered service amounts.

Financial Policy

I hereby grant permission to the EmergiCare medical staff to perform such medical/surgical procedures they deem necessary. I authorize information and subsequent visits to be relayed verbally, written, or faxed to my family doctor, commercial insurance company, employer, and/or work comp Insurance carrier, if applicable.

I understand that EmergiCare is not a participating provider for Medicare or Medicaid. I certify that I am not a Medicare/Medicaid recipient, I also understand that if I am a Medicare/Medicaid recipient that I will not be able to be reimbursed for my visit at EmergiCare.

I understand that if I am a guardian accompanying a minor, I am responsible for payment. I understand that all accounts are due and payable at the time of service if EmergiCare is not a participating provider with your insurance carrier.

I hereby authorize my representing Insurance Carrier to pay any benefits for my care to EmergiCare directly, if EmergiCare is a participating provider or if this is a Workers Compensation case.

I understand that even though I may have an insurance claim pending, I remain responsible for the account. EmergiCare does not accept responsibility for collecting an insurance claim or for negotiating a disputed claim. If insurance claims are not paid in a timely manner, then the balance is my responsibility. I understand that I am responsible for all services rendered not paid by insurance within 45 days. (Insurance reimbursement is a contract between you and your carrier. You are responsible for payment of your account within the usual limits of our credit policy.)

I read this policy and understand that, regardless of my insurance coverage that I may have, I am responsible for payment of my account within 45 days. I agree that in the event that costs or fees are incurred in connection with the collection of my account I will pay all such costs and fees including collection costs, attorney's fee and all court costs.

Signature _____ Date: _____

WORK COMP PATIENTS ONLY-PLEASE READ AND SIGN

1. The EMPLOYEE is responsible to report to Work Comp Injury, in writing, within four (4) days.
2. The EMPLOYER is responsible to fill out and mail a first report of injury to their insurance carrier within 10 days of injury notification.
3. The INSURANCE CARRIER is responsible to pay within 30 days of receiving the Work Comp bill.
4. If the EMPLOYER fails to file the first Report of Injury, the employee must file his/her own first report of injury or be responsible for the bill.
5. If the INSURANCE CARRIER "denies" the claim for any reason, the patient will be responsible for the bill.

Signature _____ Date: _____