WE CARE MEDICAL GROUP, PC
520 Bustleton Pike, Ground Floor, Feasterville, PA, 19053
Phone: (215) 631-3873, Fax: (215) 631-3899
e-mail: wecaremedicalgroup.org
website: www.wecaremedicalgroup.org

Patient Responsibility Form Agreement

Insurance Information

- The patient is responsible for providing We Care Medical Group with the most current and correct information about their insurance prior to each visit.
- We Care Medical Group will bill the insurance most recently provided by the patient with the assumption that it is current. If the information given by the patient is inaccurate and/or denied, the patient will be responsible for the balance of the visit. Please be aware that with some insurance companies, we do run into timely filing deadlines. So, providing correct information at the time of service is critical so that we can accurately bill the patient's insurance. Timely filing means that the patient's insurance plan may not pay the claim after a certain amount of time after the service is rendered.
- Patients are responsible for the payment of co-pays at the time of service.
- In the event that the patient's health plan determines a service to be "not payable," the patient will be responsible for the complete charge and agree to pay the practice costs of services **before** all services provided.
- We Care Medical Group is not responsible for knowing what each individual patient's insurance plan does or does not cover and if the provider is in- or out- of network.
- Patients are obligated to check with their insurance company about coverage before any treatments or services occur at We Care Medical Group. The patient's health insurance policy is a contract between the patient and her health insurance company. It is the patient's responsibility to know if their insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations, and limits on outpatient charges regardless of whether or not our physicians participate.
- The patient is responsible for knowing if our health care providers are in-network with their insurance plan and if the services are covered under the patient's plan.

Address/Demographic Information

- It is important that we have the patient's correct address/phone information on file.
- The patient is responsible for alerting We Care Medical Group to any address, phone or other demographic changes.

Billing Information

- If the patient owes additional money after their visit, they can expect to receive a statement mailed or sent by text message to the valid address or mobile phone number they provided to We Care Medical Group during the initial or most recent visit.
- To help keep healthcare costs down, the patient should attempt to pay their bill upon first receipt. Just as we try to make every effort to accommodate patients when they are in need of care, we expect that patients will make every effort to pay their bill promptly.

Cancellation Policy

- To best serve our patients, our policy is to charge $50 for missed appointments without prior notification, and $100 for missed procedure appointments. This fee is not covered by your insurance plan and is your responsibility. Our policy, at the discretion of the provider, is to terminate a patient from the practice after 3 missed/canceled (without 24 hours' notice) appointments.

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Financial Agreement Information

- The patient agrees that in return for the services provided to them by We Care Medical Group, they will pay their account at the time of the service is rendered or upon insurance claim processing. If payment plan consideration is necessary, the patient understands that it is their responsibility to call and make financial arrangements satisfactory to We Care Medical Group for payment. If co-payments, co-insurances and/or deductibles are assigned by the patient's insurance company or health care plan they are subject to payment **before** the medical services (procedures) provided by We Care Medical Group.
- In case of the patient during a preventive **(Annual Wellness Visit)** decides to discuss, investigate, ans treat her health problem or obtain the consultation which is outside of the scope of the preventive visit, the patient will be notified and agreed upon, the additional problem visit will be recorded, co-pay and/or deductible will be taken and submitted to the patient's insurance for reimbursement as a combined and complex visit.
- **Additional service** are available in the office, per patient(s) request, such as limited transvaginal ultrasound, sonohysterogram, intrauterine insemination and other procedures with the price agreed by the patient before the services performed and are totally optional and voluntary, not subject for insurance coverage and elected to be **self-paid**.

Self-Pay Options

- In the event that the patient is **uninsured,** or the insurance does **not cover the services/is out of network**, or if the patient does not wish to **bill the insurance**, the patient agrees to be responsible for the complete charges and to pay the practice costs of services, in full, **before** any services provided. Costs are based on the practice prices as "UCR" (usual, customary, and reasonable) rates for the self-pay services.

Failure to Pay Information

- Patients who ignore billing notices/letters and fail to pay their balance risk negative credit ratings and dismissal from the practice with transfer of the balance to the collection agency.

Financial Disputes

- In the case of financial concerns, disputes or any questions pertaining to your claim and services provided, the patient agrees to send us a letter or an email explaining the issue or request in detail and our office will gladly respond to your request within 30 days.

Guarantor Information

- Any patient over the age of 18 will be held financially responsible for all charges incurred. If another party is responsible for payment of the patient's account, please advise us who to send the statements to. The patient must pay the balance in full and do not negotiate repayment with anybody who is not listed with us as a guarantor outside of our office.

I hereby agree and consent with the Patient Responsibility Form Agreement and information. I agree to comply with the patient responsibility agreement of the We Care Medicare Group and their services provided. I understand that if I am not insured, I am responsible for the charges of all services provided to me.

____   _____/_____/________

Full Name and Signature   Date