Michael D. Maddox P.A-C Austin T. Adams M.D

M.A. PRIMARY & URGENT CARE CLINIC

WELCOME to our clinic! We are here to assist you with your medical needs to the best of our ability. Our goal is to offer quality medical care in a convenient, timely and caring manner. To offer this service, we expect financial responsibility on your part.

OUR FINANCIAL POLICY requires payment at the time of service. If you have insurance with a carrier with which we do have a filing agreement, we expect full payment from you at the time of service. We will provide you with an itemized statement that you may file with your insurance company for application toward your deductible or for reimbursement of charges.

IF WE HAVE AN AGREEMENT WITH YOUR INSURANCE COMPANY, it is **YOUR** responsibility to:

1. Provide us with information relative to your claim, including insurance card, employer, date of birth, correct address and phone number and Social Security number. All this information is requested on your patient registration form.

2. Pay your co-payment at the time of service.

3. Pay for any services not covered by your insurance company.

We accept in state personal checks with proper identification. A $20.00 overdraft charge will be added to all returned checks.

WHEN YOUR BILL REMAINS UNPAID FOR 60 DAYS, it will be turned over to a collection agency. If your account is placed with a collection agency, you will be responsible for all costs of collection, including attorney's fees, and court costs.

LASTLY, we do not accept Medicare or TennCare. If you have TennCare, you need to see your assigned physician. If you have Medicare, we expect payment at the time of service. We will provide you with an itemized statement, which you can file for reimbursement.

I HAVE READ AND FULLY UNDERSTAND MY FINANCIAL RESPONSIBILITIES UNDER THIS POLICY.

PATIENT NAME (PRINT): _____**DATE:**_____

PATIENT or GARDIAN SIGNATURE:_____

ASSIGNMENT AND RELEASE:
The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and /or dependents. I further expressly agree and acknowledge that my signature on this document authorizes M.A. Primary and Urgent Care Clinic to submit claims for benefits, for services rendered or for service to be rendered, without obtaining my signature on each and every claim to be submitted for myself and /or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim:

I _____, hereby authorize the insurance company listed to pay and herby Assign directly to
[NAME OF INSURED]

M.A. Primary & Urgent Care Clinic all benefits, if any, otherwise payable to me for his services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to M.A. Primary & Urgent Care Clinic, will be credited to my account, in accordance with the above said assignment.

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[AUTHORIZED SIGNATURE OF SUBSCRIBER] [DATE]