PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing HovaCare Clinic for your healthcare needs. We are committed to providing you with the highest quality healthcare service. We ask that you read and sign this form to acknowledge your understanding of our financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor), or financial guarantor is ultimately responsible for the payment of treatment and care received at HovaCare clinic.
- We will bill your insurance for you. However, you or financial guarantor is required to provide the most correct and updated information regarding insurance plan and coverage.
- The Patient (or patient's guardian, if a minor), or financial guarantor is responsible for payment of Co-pays, Coinsurance, Deductibles, for all other non-covered procedures or treatment
- **Co-pays are due at check in prior to services rendered**. The amount payable is shown on your insurance card.
- Patients that **DO NOT have an office Co-pay are required to pay $30 for part payment of Coinsurance, Deductibles, Non-covered items, and all other payments not covered by your insurance plan at the time of check in**.
- Patients with **HIGH DEDUCTIBLES are required to pay $100 towards the office visit at check in.**
- Full payments of Coinsurances, Deductibles and Non-covered items are due 30 days from receipt of billing.
- **Private self-pay patients (without insurance) pay $300 for new or $230 for returning or follow up visit at time of registration**. **Depending on the services rendered, additional charges may be incurred and full payment is due at check out**.
- The Patient (or patient's guardian, if a minor), or financial guarantor may incur, and are responsible for payment of additional charges, if applicable. These charges may include: ***Charges for RETURNED CHECKS -$25**
- **Medicare deductible and co-insurance**. Medicare requires you pay out of pocket an **annual deductible at the beginning of each year**. You are also responsible for the **20% co-insurance payment**. If you have not met your deductible, we will collect a **minimum of $100 towards the 1st office visit of the year**. Payment is due at check in.
- By my signature below, I hereby authorize assignment of financial benefits directly to HovaCare Clinic and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I confirm that I have read and will abide with the policy above.

Patient Name_____

Patient Guardian (if minor) /Financial Guarantor Name_____

Patient/Patient Guardian (if minor)/Financial Guarantor Signature_____

Date_____