NEWCare
New England Wound & Ostomy Care

FINANCIAL AGREEMENT

Patient Responsibilities

- You are responsible for providing us with accurate billing information at the time of service.
- If your insurance company requires you to have an insurance referral, you are responsible for contacting your primary care provider to ensure the referral is in place prior to your visit with us.
- Our billing staff is available to provide you with assistance but cannot resolve disputes between you and your insurance company.

Co-Payments

- Your insurance company requires you to pay your copay at the time of each visit.
- Your copay may be paid with cash, check, credit card or debit card.
- If you do not have insurance coverage, you will be expected to pay for your visit in full upon arrival for your appointment.

Deductibles

- It is your responsibility to understand any deductibles that may apply to you under your Insurance Policy.
- Our billing department will send you a statement of the amount your insurance company has determined is applied to your deductible and is owed by you.

Insurance Information

- It is your responsibility to ensure that we have accurate insurance information. Presenting an invalid or inactive insurance card will result in full payment by you.
- Medical insurance does not always cover the entire cost of your medical care. You are responsible for payment if your insurance company refuses to pay for a service.

Home Address and Telephone

- You will be asked to complete a patient registration form that asks for important information about you. Please complete this form to the best of your knowledge and keep us informed of any changes on subsequent visits.
- It is important that we have accurate information on the guarantor. This is the person who is financially responsible for your bills.

Assignment and Release

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize my Physician to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. Recent changes in insurance regulations shorten the time frame for claim submissions. I agree to pay any out-of-pocket expenses in full to New England Wound Care within thirty days from the date of my visit for uncovered, denied services by my presented insurance coverage or for No-Show fees.

Signature: _____ Date: _____

Printed Name: _____

Witness: _____ Date: _____