ELECTRA
MEDICAL CLINIC

Financial Information and Responsibility

Electra Medical Clinic is committed to assisting patients meet their payment obligations, and we are pleased to discuss our fees, billing practices, or your responsibilities with you at any time. Our billing policies are available upon request. Electra Medical Clinic is a division of Electra Memorial Hospital and contracts some services to other providers. Patients may receive a separate bill from Electra Memorial Hospital or other providers such as a Pathologist or Radiologist for services rendered.

FINANCIAL RESPONSIBLITY

- All patients must complete this form before seeing a provider.
- Patients or their guarantors are responsible for fees not covered by insurance including deductibles, copayments, coinsurance, and non-covered services.
- Patients or their guarantors are responsible for making payment or arrangement for payment at time of service.
- We accept cash, checks, Visa, MasterCard, Discover, and American Express.
- Electra Medical Clinic files insurance claims as a courtesy to our patients. We do not become involved in disputes with insurance companies other than to supply factual information as necessary. Patients are responsible for the timely payment of their account. If an insurance company pays more than the balance due, we will refund the money to the patient at the end of the month.
- Patients must provide copies of their insurance card(s) and notify Electra Medical Clinic of any changes in insurance coverage.

FINANCIAL INFORMATION

Primary Insurance _____ Policy # _____ Group#_____

Insured Name:_____ SSN:_____

DOB:_____ Relation to patient:_____

Secondary Insurance _____ Policy # _____ Group#_____

Insured Name:_____ SSN:_____

DOB:_____ Relation to patient:_____

Other Insurance _____ Policy # _____ Group#_____

Insured Name:_____ SSN:_____

DOB:_____ Relation to patient:_____

I understand my financial responsibilities and authorize payment to the provider of all medical benefits for services rendered.

_____ _____

Patient Name (printed) Date of Birth

_____ _____

Patient / Guarantor Signature Date