Global Care Medical Group, P.C.

Our Financial Policy

Thank you for choosing us as your Primary Care Provider. We ask that you **carefully** read and sign the following Financial Policy

****We require a copy of <u>All</u> insurance cards and ask that you present them at <u>Each</u> visit****

Participating Insurances

We participate with many insurance companies.
Co-pays are due at time of service.

Non-Participating Insurances and Self Pay

Payment in full is required at the time of service. As a courtesy, we will bill your insurance.

For All Insurances

Please review your benefit listing summary that you received from your insurance company to understand your coverage

Medical Record Copy Fee

There is a fee for medical record copies in certain specified circumstances of flat fee $ 20.00

Payment Methods

Cash, checks, Mastercard, VISA, Discover, and American Express are accepted.

For certain situations, we will accept credit card payment plans.

Non-Copayment plans

If your plan does not require a copay and we participate, you are responsible for any deductible or balance that your plan indicates on the explanation of benefits.

Returned Checks

There is a $15.00 fee on all returned checks.

Choosing Global Care as your PCP

If your plan requires you to pick a Primary Care Physician, it Is your responsibility to ensure that we are listed as your PCP. If we are not, you will be responsible for any incurred charges.

Account Balances and Collection Procedures

You are responsible for timely payment of your account. Global Care Medical Group reserves the right to reschedule or deny a future appointment on delinquent accounts. If sent to collections, you may be required to pay any expense or costs relating to the collection proceeding, including reasonable attorney fees and court costs.

I understand and agree that insurance policies are an agreement between an insurance carrier and myself. I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I authorize Global Care Medical Group, P.C., to furnish information to insurance carriers concerning my illness and treatments.

I understand that if I terminate or suspend my care and treatment, any fees including a reasonable fee as allowed by public health law for copying of medical records will be immediately due and payable. I understand that if it becomes necessary to have delinquent balances referred to an attorney or collection agency, I agree to pay any and all attorney/agency fees to collect the outstanding bills.

In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for all services rendered to the patient herein.

______________________________ Patient Signature ______________ Date

______________________________ Patient Print Name ______________ Date

Parent/Guardian Print Name: ______________________________

Parent/Guardian Signature: ______________________________

Print Patient Name if Minor: ______________________________

(revised 08/09/16)

Global Care Medical Group, P.C.
Lowell and Tewksbury Location

Date:______________________

Thank you for taking the time to complete this form. Accurate information ensures timely claim submission and helps to avoid billing problems for you and the practice.

Name:___________________________ Sex M___ F___ DOB:_______________

Social Security #:______ -______ - ______ Email_______________________________

Race:____________ Ethnicity:_____________ Preferred Language:__________________

Street Address/apt #____

City:____________________________ State:__________ Zip:________________

Preferred phone :______________________________Can you receive text messages Y/N

Emergency Contact Name:____________________ Emergency Contact #:_________________

Pharmacy name & phone number:____

INSURANCE INFORMATION

Guarantor Name (card holder):_______________________________ DOB:_____________

Guarantor Address:____

City:____________________________ State:__________ Zip:________________

Relationship to Policy holder: Self____ Spouse____ Child____ Other____

Insurance Plan:____

Policy #:_______________________ Group #:________________ Copay $:_________ (at office)

SECONDARY INSURANCE (if applicable)

Insurance Plan:____

Policy #:____________________________________ Group#:______________________