AllCare
Primary Care & Walk-ins

July 2010

OFFICE POLICIES

Patient's Name: ____ Date of Birth:__________________

APPOINTMENTS OR WALK-IN

If you need to see the Practitioner/Physician regarding lab work, routine office visits or non-emergency visits, please schedule an appointment. This appointment will allow you and the Practitioner/Physician the time necessary to answer all questions. **Walk-in patients are not considered established patients until the Establishing Care Process has been completed and the Physician accepts your case.**

I understand that AllCare provides care on a walk-in basis; which by no means is intended to be a complete diagnosis or complete medical care. My Visit Summary may include instructions to contact a physician for continued medical diagnosis and care, as I will do.

_______________**PATIENT'S INITIALS**

SELF PAY OR DEDUCTIBLES

Payment is due at the time services are rendered. We do not bill patients for visits or procedures. We accept cash, debit and credit cards.

_______________**PATIENT'S INITIALS**

As a courtesy to our patients, we will submit your claim to your insurance company. Once you receive our bill for any part that is your responsibility, payment is due upon receipt. If you are unable to pay your balance in full, please contact our office to make satisfactory payment arrangements.

_______________**PATIENT'S INITIALS**

All delinquent accounts will be referred to the credit bureau. If this occurs, please be advised that it will appear on your credit report. All returned checks will be subject to a $25.00 non-sufficient funds fee. We will forward all back check writers and delinquent accounts to an attorney and you will be responsible for all costs incurred. The county attorney may prosecute any violations of Sections ARS13-1807. We have a copy on file if you need to read it in more detail.

_______________**PATIENT'S INITIALS**

In the event of a disturbance or disruption by patients and/or visitors, at AllCare Internal Medicine or on the phone with an AllCare employee, action will be taken to prevent physical injuries to staff, patients, and visitors.

_______________**PATIENT'S INITIALS**

ASSIGNMENT AND RELEASE

We ask all patients to show their insurance card and a photo ID at each time of service, so that we may make a copy of the card for our records. Please contact our office if your coverage has changed.

I understand that I am responsible for any non-covered services. I direct the insurer to pay, without equivocation, directly to the physician, all benefits due as results of any claims. Although covered by insurance, I am aware that I am personally responsible for all charges. I authorize the physician to release any information required to process this claim. If there is a problem collecting from my insurance company, I authorize for the physician to submit on my behalf, a complaint to the insurance commission in order to obtain payment from my insurance company.

____ ____________________

Patient Signature Date

____ ____________________

Legal Guardian/Representative Signature (if Minor) Date

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