410 College Road
Greensboro, NC 27410
Phone 336-218-0994
Fax 336-218-0997

Complete Family Medical Care
Minor Injuries
Work/Personal Injuries
www.friendlyurgentcare.com

Friendly Urgent and Family Care

Statement of Patient Financial Responsibility

Patient Name: _____ **DOB: _____**

Friendly Urgent & Family Care appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, you will be responsible for your balance in full.

CO-PAY POLICY - Some health insurance carriers require the patient to pay a co-pay for services rendered. We accept the following forms of payment; cash, credit and debit cards. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

To acknowledge that you have read and understood the above policy, please sign below.

Patient/Parent/Guardian Signature _____ Date: _____

POLICY FOR NON-INSURED PATIENT'S

- I do not have health insurance and will be responsible for services rendered here at Friendly Urgent & Family Care

- Payment is expected ***IN FULL*** at time of the service. We do not bill for any services rendered.

- We do secure payment prior to being seen. Our policy requires that we hold a minimum of $100 if paying by cash, or we may hold a credit or debit card. Charges are not applied to your card until after you have been examined by the physician

To acknowledge that you have read and understood the above policy, please sign below.

Signature: _____

Date: _____