Patient Financial Agreement

SELF REGIONAL HEALTHCARE

PLEASE READ THOROUGHLY AND SIGN BELOW.

In consideration of receiving services from a Self Regional Healthcare (SRH) facility, you agree:

1. All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered.

   KNOW YOUR BENEFITS. You also authorize and direct Self Regional Healthcare to apply any overpayment to other Self Regional Healthcare affiliate accounts of yours, your spouse, or your dependent children.

2. **On the date of service**, we will collect your deductible, co-pay, co-insurance and payment for any uncovered services as well as the patient's portion as determined by insurance. We accept cash, check, debit card, and credit cards for MasterCard and Visa. You also authorize and direct Self Regional Healthcare to apply any overpayment to other Self Regional Healthcare affiliate accounts of yours, your spouse, or your dependent children.

3. Your insurance policy is a contract between you, your employer, and the insurance company! We are NOT a party to that contract. It is your responsibility to notify this office immediately if your insurance coverage or company changes. **It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements, and to be sure all insurance information is current. KNOW YOUR BENEFITS.**

4. We will bill your insurance company as a courtesy, but you are still ultimately responsible for payment of all services you receive. If your insurance company does not respond within 30 days we will follow up with an inquiry on your behalf. If, however, your insurance does not respond within 60 days of claim submission, a statement will be sent to you. You should call your insurance to question why the claim is not paid. Our office will assist you only after you have contacted your insurance.

5. If your medical claim has not paid and your insurance company has not resolved your dispute you may register a complaint with the South Carolina Department of Insurance. Our office will do everything we can to assist you; however, you must understand you cannot delay payment while you are awaiting the outcome of your complaint.

6. Any unpaid charges over 90 days old will be considered for an outside collection agency. You are responsible for any collection fees, legal fees, or court costs incurred in the collections process. This agency will report your failure to pay to the THREE (3) national credit reporting agencies.

7. We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account. Please call (864)725-7800 Monday through Friday from 8:30 a.m. to 5:00 p.m. for customer service.

8. **Non-Insured:** If you do not have medical insurance, you will be responsible for a minimum payment at the time of service for the service to be received that day, as well as any previous outstanding balance. If a procedure is necessary, payment may be required prior to the procedure. We offer a 20% discount for payment in full at time of service.

9. This office offers access to many innovative services and procedures, and some of them are deemed as "not covered" by insurance. In some cases, you will be given a waiver for these types of services/procedures before they are provided/performed. You will be responsible for payment in full at the time of service.

10. Returned checks are subject to a $25.00 return check fee.

11. **Release of Information:** You assign benefits of your medical insurance contract, Medicaid or Medicare to SRH and authorize payment directly to SRH. You authorize SRH to release medical information to payers as required for payment of claims for medical services.

We are committed to providing you with the best possible care and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

I have read and understand this Patient Financial Agreement. Date: ______________

Patient/Guardian Print Name ____________________________________ Signature ________________________________