ISLAND URGENTCARE

Hawaii Kai- Waikiki –Pearl Kai -Kakaako
Corporate Office 808-735-0007

Payment and Insurance Financial Policy

PATIENT NAME: ________________________________ VID#:________ DATE OF BIRTH: ______________________

Thank you for choosing Island Urgent Care for your medical care. We are committed to providing access to the highest quality affordable health care. We ask that you read and sign below to acknowledge your understanding and acceptance. A copy will be provided to you upon request.

1. **FEE FOR SERVICE:** If you do not have insurance, you can be seen at Island Urgent Care. However, you will be responsible for payment of all charges incurred. ***Payment will be due in full at the time of service.***
2. **INSURANCE:** IUC participates with most insurance payers. Insurance verification will be done at time of service, when possible.
3. **PROOF of INSURANCE & IDENTIFICATION**: Patient's must provide a ***valid insurance*** card with a member ID and a ***valid State ID, driver's license, or passport***, to validate identity. IUC will secure this in your electronic medical record. If you are unable to produce a form of acceptable identification, then IUC cannot bill your insurance. IUC follows the HIPAA guidelines (Act of 1996 (HIPAA), Public Law 104-191), in preventing insurance fraud, by asking you to provide accurate, up-to-date personal identification and insurance information at the time of service.
4. **CO-PAYMENTS AND DEDUCTIBLES:** Most payers require a co-payment and or co-insurance for each visit. IUC collects these amounts at check-in. Depending on the insurance carrier; there may not be sufficient information to determine the total amount of your co-payment(s), co-insurance, and/or deductible at the time of your visit. We do not accept personal checks as form of payment at check in. A Credit Card is required to bill a payer/insurance.
5. **AS PART OF YOUR TREATMENT**. IUC may refer you out to other facilities for additional studies (labs, X-ray, CT, MRI, U/S.) You will receive a separate bill from this entity for the additional studies (labs, X-ray, CT, MRI, U/S). You will be responsible for these additional costs, depending on your insurance plan, up to and including 100% of expenses if you have a high deductible. Please check your insurance plan.
6. **E MAIL:** An email is preferred to communicate with your regarding your account and billed services including statements and other information.
7. **NON-COVERED SERVICES:** Please be aware that some, and perhaps all, of the items or services you receive may not be a covered benefit under your insurance plan. Your insurance benefits are determined by the plan chosen. It is your responsibility to contact your insurance company if you have any questions or concerns.
8. **CREDIT CARD ON FILE:** IUC has an automated billing process. As such, IUC requires a debit or credit card on file to expedite claim resolution. This information is held confidentially according to the highest national security standards (PCI Standards) for security purposes. Once your insurance has adjudicated your claim, the remaining balance will be automatically deducted from your credit card account 5 days after your first statement date. Payment notification and receipt will be emailed to you. ______ Patient Initials
9. **NO CREDIT CARD ON FILE:** If no credit card is left on file to charge for remaining balances, a statement will be sent to patient for balance due. If this balance is not paid within 10 days from the date of this statement account will be sent to a collections agency. ______ Patient Initials
10. **CLAIMS SUBMISSION**: If IUC participates with your healthcare plan, IUC will submit your claim, as a courtesy, to the insurance company noted on file. It is sometimes necessary for the insurance company, and or IUC billing department, to contact you directly for information or assistance. It is your responsibility to comply with this request in a timely manner. Please understand that the balance of your account is your responsibility whether your insurance company pays the claim or not.
11. **COVERAGE CHANGES*: Please notify IUC billing if your insurance or plan changes.*** IUC will make the appropriate changes to assist in correcting the claim and obtaining the plan's maximum benefits. Please notify IUC within 30 days of your visit of any insurance changes. If incorrect information is sent to the Insurance Company, a denial of claim will occur. Any denial will result in the entire balance becoming patient responsibility.
12. **CREDIT CARD DECLINES**: If your Credit Card on File is declined, we will send you one notice and your payment will be rescheduled. If the card declines a second time and no additional payment is made to settle the balance within the given timeframe, your account will incur a $50 admin fee and will be forwarded to a collections agency.
13. **RETURNED PAYMENTS**: A $50 nonrefundable admin fee will be assessed for each NSF check payment or charge-backed credit card payment. Patient will have 10 days to settle balance or account will be forwarded to collections agency.
14. **STATEMENT COURTESY**: IUC provides regular account statements on day 3 and 30 after insurance has paid their policy amounts. It is your responsibility to review these statements for accuracy and respond immediately to any and all requests for information and payment. We are required by federal law to support all services rendered with proper documentation in your medical records. Please understand that in the event that your account is referred to collection agency you will be responsible for any additional costs attributable to that action including, but not limited to, collection agency, attorney and court costs incurred and permitted by the laws governing these actions. Patients with outstanding balances will be required to pay in full prior to being seen.
15. **ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** IUC enforces your privacy rights to the full extent of all local, state and federal laws and maintain the privacy of your personal health information. At your request, IUC will provide you with a Notice of Privacy Practice, which further describes this policy.
16. **THIRD PARTY LIABILITY**: Injuries that did not occur at work or did not involve a motor vehicle, and you believe were caused by a third party who you think should be responsible, will be considered third party injuries. Some examples of third party injuries are injuries that occur at stores, restaurants, or on sidewalks, and a third party may or may not be responsible, and/or liable. ***Island Urgent Care will not seek payment from the third party on your behalf***. The cost of a visit due to an injury from a third party will be due in full at time of service. We will give you an itemized receipt to submit to the party you think is responsible for your injury for reimbursement.

I have read, understand and agree to the guidelines outlined in this policy. Your parent or legal guardian must sign below, if you are under the age of 18

Signature Required: ____ Date of Service:______________________

If patient is under the age of 18:
Parent/Legal Guardian's printed Name: ______________________________ Relationship to Patient:__________________

❑ IUC STAFF INITIALS: _______ Last Updated: 9.5.2018