Stafford HealthCare Clinics
Established 1980
Walk In Clinic ◆ Occupational Medicine ◆ SEDA

PAYMENT POLICY

REVISED FORM 01 2014 ©

Stafford HealthCare Clinics works on a 'NO BILLING' policy and PAYMENT IN FULL IS REQUIRED AT THE TIME OF VISIT .

Welcome, please complete registration forms and present your insurance card and picture ID to the front desk. If you are unsure if your insurance is accepted at this clinic or your coverage's with such, please ask the front desk and / or contact your insurance provider. Patients without insurance or with private plans we currently do not accept *are welcomed*, however, payment for services is required at the time of service. We are not a Medicare provider, our doctors cannot see Medicare or eligible patients, only medical services provided by our nurses are available, with a signed private contract.

All Insurance Accounts Must Be Paid In Full Within 90 Days Regardless Of Pending Payments. Any credit balances over ten dollars remaining after insurance payments will be refunded; Balances less than ten dollars will be posted to the patient account for future use. Account balances less than ten dollars will be refunded, upon individual request . Verification of insurance and eligibility is required prior to treatment.

Office visit charges for established and new patients (*patients not seen in past 3 years*) are determined by the level of service provided. Office visits are $95.00-$200.00 and increase depending on level of service provided; expanded office visits, patients with multiple concerns, are charged accordingly. Lab work, X-rays, procedures and medications are an additional charge. Physicals are priced according to depth of details required. Immunizations, vaccinations and therapeutic injections are priced individually and not by series. Our policy requires payment at time of service for all immunizations.

If you are sent by an employer for a medical exam and / or treatment, verification of both employment and payment is required prior to medical treatment. In the event your employer does not pay for medical treatment , you understand that you are solely responsible for all charges and do agree to pay any and all charges.

Thank you for choosing Stafford HealthCare for your medical needs.

Patient Information

Is Your Visit Today? - (PLEASE ✓ YES or NO)

Medicaid	☐ YES ☐ NO	Altercation Related	☐ YES ☐ NO	Method of Payment	☐ CASH (US currency)
Medicare	☐ YES ☐ NO	Motor Vehicle Accident	☐ YES ☐ NO	Today Will Be:	☐ CHECK (Blank Unprinted Starter Checks not accepted)
Champus /Tricare	☐ YES ☐ NO	Work Related Injury	☐ YES ☐ NO		☐ Visa/MC/AX/Discover (Cardholder must be present)

Work Related Injuries Must Be Verified And Covered By Employer Prior to Visit

Please Print:

Patient Name: _____ Date of Birth: _____ Age:_____

Sex: M F Social Security # :_____ Marital Status: S M W D

Address: _____ City: _____ St :_____ Zip: _____

Physical Address: Same ☐ If different from mailing address: _____

Phone:_____ Race: ☐ White ☐ Black ☐ Asian ☐ Hispanic ☐Other:_____

Cell Phone:_____ Insurance Carrier:_____

Patient's Employer:_____ Phone: _____ Occupation:_____

Address: _____ City: _____ St :_____ Zip: _____

Notify in case of Emergency: _____ Relationship:_____ Phone: _____

(Someone not living in same household)

Spouse Information

Name:_____ Employer: _____ Phone:_____

Minor Patients : Parent / Guardian Information (If Applicable)

Mother's Name:_____ Address: _____ Phone:_____

Mother's Employer:_____ Phone:_____

Father's Name:_____ Address: _____ Phone:_____

Father's Employer:_____ Phone:_____

I authorize the release of any and all medical information concerning my (or my child's) health care necessary to process all claims created through this clinic limited to health insurance and workers' compensation. I understand and agree to any and all reasonable fees (not to exceed 30% of balance due) incurred as a result of a failure to pay the balance in full, causing the placement of this account with a collection agency and or attorney. I have been provided a copy of Stafford HealthCare Clinics' Notice of Privacy Practices. I have read, understand and agree to these clinic and payment policies.

Signature of Patient / Guarantor: _____ Date: _____