



PATIENT FINANCIAL AGREEMENT

Patient Name (First and Last): _____ Date of Birth: _____

Thank you for choosing DMC Primary Care for your healthcare needs. In order to provide services, we ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

INDIVIDUAL FINANCIAL RESPONSIBILITY: You are financially responsible to pay for all charges incurred for services and procedures received at DMC Primary Care (DMC) and agree to the following:

Proof of Insurance: It is your responsibility to provide DMC with a copy of your current health insurance card(s), and to update DMC as soon as possible regarding any changes to your insurance(s).

Non-covered Services: If you are provided a service that is not covered by your insurance plan, you are responsible for any remaining balances. There may be circumstances when a separate signed waiver may be requested by DMC.

Uninsured: If you do not have insurance, you will be considered a private/self-pay patient and will be responsible for payment at the time of service, as well as any remaining balances billed to you after services are rendered.

Co-payments and Balances After Insurance: Insurance co-payments are due at the time of the visit. Any balances related to deductibles and/or co-insurance must also be paid.

Outside Laboratory: Services sent to an outside laboratory are billed by the laboratory, not DMC. You will receive a separate invoice from the laboratory.

Payment for Services: Payment to DMC may be made in the form of cash, check, or debit/credit card. If you receive payment directly from your health insurance carrier, you agree to endorse or forward payment to DMC for services provided to you by DMC.

Patient Credits: Any patient credits will be applied to other outstanding patient balances owed for any other DMC or Derry Imaging Center services received, prior to any refund being issued.

Assignment of Insurance or Health Plan Benefits: You agree to assign and authorize direct payment to DMC for all insurance and health plan benefits and settlements, whether medical or liability insurance (including but not limited to, the proceeds of any settlement or judgement of any third-party claims) as payment for any and all services performed at DMC.

Assignment of Medicare Benefits: You certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. You request the payment of authorized benefits be made on your behalf to DMC and its healthcare professionals rendering care and/or treatment to you, and authorize DMC to submit claims to Medicare for payment, if applicable. You authorize DMC to release to Medicare and its agents any information needed to determine these benefits for related services.

Filing of Third-Party Claims: Upon proof of coverage, DMC will submit a claim for payment of insurance benefits and accept payment from third party payors to be credited to your account, as they are received. The filing of insurance claims by DMC is performed as a service and in no way relieves you of the obligation to pay in full.

Authorization to Release Information: You authorize DMC to release your health information to insurers, governmental agencies or any other entity financially responsible for your medical care, in order to substantiate payment for such medical services, or as required for pre-certification, authorization, or referral to other medical provider(s).

Consent to receive text and email notifications: You consent to receiving electronic notifications regarding your balances and financial responsibilities via text message and email. You may opt out of receiving electronic notifications at any time.

Discharge: Ongoing failure to meet your financial obligations to DMC may result in your discharge as a patient.

I confirm that I have read, understand, and accept the terms of this document and that I am the patient or the patient's legal representative, duly authorized to accept the terms and execute this document.

Signature of Patient/Legal Representative

Printed Name/Relationship to Patient

Date