FINANCIAL AGREEMENT

LAKEWOOD URGENT CARE

Patient Name: _____

Patient Date of Birth: _____ Patient Social Security Number: _____

IF APPLICABLE:

Guarantor's Name: _____

Guarantor's Date of Birth: _____ Guarantor's Social Security Number: _____

DISCLOSURES & CONSENTS

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Lakewood Urgent Care's affiliated professional associations or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Lakewood Urgent Care is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my, or my dependent's, records that these programs may request. I hereby direct that payment of my, or my dependent's, authorized benefits be made directly to Lakewood Urgent Care's affiliated professional associations or the physician on my behalf.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

FINANCIAL RESPONSIBILITY AGREEMENT:

I understand and agree that I am, and will be, financially responsible for any and all charges for services not paid by my insurance. This may include medical services/physician visit, preventative exam/physical lab testing, EKG, and/or any other screening or diagnostic testing ordered by the physician.

I understand and agree it is my responsibility to know my insurance benefits for series done in the office and ordered by the physician.

I understand and agree it is my responsibility to recognize the physician is contracted with my insurance and I have verified the physician is an 'In Network Provider' through my insurance. If the physician is not contracted and is considered an 'Out of Network Provider', my insurance benefits may be reduced or denied and I will become financially responsible for any unpaid amounts.

I understand and agree that Lakewood Urgent Care, or our authorized agents, will be able to contact me electronically and via phone in order to collect balance accrued from previous dates of service.

All balances must be paid within 30 days from the date of invoice. Patient agrees to pay a delinquency charge of 1.5% per month (18% per annum) on any outstanding balances owed by patient and not paid after thirty (30) days from invoice date until patient renders payment in full. If Lakewood Urgent Care must pursue legal action against patient to collect any amounts owed by patient to Lakewood Urgent Care, patient agrees to pay Lakewood Urgent Care's expenses, including reasonable attorneys' fees, incurred as a result of the legal action.

I understand and agree if my plan requires a Primary Care Physician (PCP), it is my responsibility to change the PCP to the physician at Lakewood Urgent Care. If I do not choose to change the PCP, it will be my responsibility to obtain a referral, if needed, and/or be responsible for any amounts not paid by said insurance.

I understand and agree that payment for the above services, including deductibles, co-insurance, co-payments, based on usual and customary fees, is due, in full, at time of service.

_____ _____

Patient Signature Date

_____ _____ _____

Guarantor Signature Relationship to patient Date