

**PRINCETON PRIMARY AND URGENT CARE CENTER, LLC**  
707 Alexander Road, Suite 201  
Princeton, NJ 08540

## **OUR FINANCIAL POLICY**

Thank you for choosing us as your health care provider. We are committed to your health care. The following is a statement of our financial policy, which we require that you read and sign prior to any office visit.

**We must have a copy of your insurance card.** *Deductibles/Copays/Coinsurances* are portions that you owe and we are legally bound to collect these from you based on our contract with your insurance companies. While we strive to provide the best medical care possible, **COLLECTING PAYMENT AT THE TIME OF SERVICE** will keep our practice run efficiently.

As you know, most service merchants like hotels, car-rentals etc, asks for a **CREDIT CARD**, which is imprinted and later used to pay your bill. This system offers convenience, makes bill payment/settlement easier, faster and more efficient. Our office has implemented a similar policy. You will be asked for a credit card (Visa, Mastercard or Discover) at the time you check in. We will take an imprint of your credit card and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share.

While we strive to be precise in collecting these deductible amounts upfront, there may be discrepancies once the claims are actually processed. You may pay more or less than the negotiated amount. If you have paid more, you have the option to have a credit from us or request a refund. If we have collected less than the negotiated contract, we will charge your balance on your Credit Card we have on file. This will be convenient for you, since you will no longer have to write out and mail us checks. It will be an advantage to us since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping reduce the back office expense and keep the cost of health care down. This will not, in anyway, compromise your right to dispute a charge or question your insurance company's determination of payment.

**Thank you for your understanding of our financial policy. Please let us know if you have any questions or concerns.**

I have read the Financial Policy (above). I understand and agree to this Financial Policy.

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Signature of Patient or Responsible Party

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Date