

Hart Family Health PC  
8101 O Street, Suite 120  
Lincoln NE 68506

**Financial Responsibility Acknowledgement**

**Patients without health/medical insurance coverage (self-pay):** Payment in full is requested and expected at the time of service. If you are unable to remit payment in full please make alternative arrangements.

**Patients with health/medical insurance coverage:** As a courtesy, we will file claims with your primary and secondary insurance (if applicable) providing we have your *Assignment of Benefits* (see below) and **current and accurate** insurance information from you. Please keep in mind that *NOT ALL SERVICES ARE A COVERED BENEFIT OF ALL PLANS* and that your insurance coverage is an agreement between you and your insurance company. Insurance plans have timely filing limits. If the timely filing limit has been exceeded and you fail to provide accurate insurance information, you will be responsible for ALL incurred charges. All copays are due at the time of service. If coinsurance information is available from your insurance plan, you will be requested to remit this amount at the time of service upon checkout.

**Presentation of your insurance card will be requested at each appointment.**

**Patients with Medicaid:**All patients receiving state funded healthcare benefits are required to provide accurate identification information for the specific plan they are enrolled. *NOT ALL SERVICES ARE A COVERED BENEFIT*. Review your Medicaid manual if you are not sure of coverage. Share of Cost forms will only be completed with receipt of payment. **Presentation of your state issued Medicaid card will be requested each appointment.**

**Patients claiming Workman's Compensation/Third Party Liability (i.e. auto accidents):**

As a courtesy, we will file claims with your workman's compensation carrier provided all billing information is provided and ACCURATE. If the information provided is not accurate, you are responsible for all incurred charges. Hart Family Health, PC will not file claims with any other third party carrier as we are not obligated by contract to do so. (i.e. auto accidents, etc.) Patients will be responsible for all charges incurred.

**Court Orders regarding dependent care/medical bills:**

Court orders regarding medical expenses are between the person listed in the court order and NOT Hart Family Health. The person's signature on this form will be responsible for payment.

**Billing:**

All balances are due in full upon receipt of a mailed statement. If you are unable to remit payment in full, you are required to make arrangements with Hart Family Health. Failure to remit payment or correspond with Hart Family Health may result in your account being subject to further aggressive collection efforts. Accounts subject to additional collection efforts will result in the responsible billing party and associated family members having medical services suspended and subject to termination from the practice. **ANY ACCOUNT BALANCE TURNED OVER TO AN OUTSIDE COLLECTION AGENCY WILL RESULT IN TERMINATION FROM THE PRACTICE.**

**NO SHOW POLICY**

The purpose is to assure patients have access to care when needed by maximizing the utilization of available appointments. Your appointment is counted as a **No Show** if: 1 You do not call us or do not show up at all  
2) You do not cancel your appointment, if possible, 24 hours in advance.

Having **three (3) No Show** appointments combined by your family/household will result in termination of further professional attendance upon you and members of your family/household.

**FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS**

I have read and agree to the terms and conditions set forth above. I understand that I am responsible for and agree to pay all charges regardless of insurance coverage or pendency of claims. I authorize the release of all medical information necessary to process my health insurance claim and request payment of benefits be made to Hart Family Health, PC. A photocopy of this agreement shall be as valid as the original. I understand that I can withdraw this medical benefit assignment at any time by notifying this office in writing.

Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date \_\_\_\_\_

Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_