



301-330-0006

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AllDayMedicalCare.com

702 Russell Avenue, Suite 100  
Gaithersburg MD 20877

3915 Ferrara Drive  
Silver Spring, MD 20906

3508 Worthington Blvd, Suite 101  
Urbana, MD 21704

5525 Twin Knolls Road, Suite 323  
Columbia, MD 21045

## ALL DAY MEDICAL CARE CLINIC: FINANCIAL POLICIES & AGREEMENT

***If an appointment cannot be kept, please contact the office at least 24 hours in advance.  
There will be a \$100.00 fee for late cancellations and a no shows that are self-pay or private insurance.  
Medicaid patients are exempt from any and all out of pocket fees.***

### INSURANCES

Please check with your primary insurance to ensure that services will be covered. It is your responsibility to verify that we have your most current address, phone number and insurance information on file.

If we participate with your insurance company, we will submit all services performed in our office for reimbursement unless we have received prior notification of non-covered services. All copays, deductibles, and overdue balances are your responsibility, and payment is expected at the time of each visit.

If we do not participate with your insurance company, you are responsible for payment in full at the time services are rendered (*Please see Insurance Waiver*)

Insurance companies often require pre-authorization as a condition of reimbursement – whether or not we participate with them. It is your responsibility to obtain any required insurance referrals or authorizations prior to your visit. If a required referral is not presented at the time of your visit, you will then be required to pay for the cost of your service.

### PAYMENT FOR SERVICES

Payment for each visit is expected at the time of service. For your convenience, we accept all major credit cards, cash, or check. Returned checks will incur a \$35 fee to each patient account affected. All patient payments including any outstanding balances are due at the time of service – unless prior arrangements have been made with the Billing Department.

You will be charged for missed appointments if you fail to provide 24 business hours' notice. You are fully responsible for these charges because they are not covered by your insurance.

Overdue accounts may incur late fees at 20% per month. All balances that become 90 days past due may be sent to a professional collection agency. Should your account be sent to a collection agency, you will be financially responsible for a collection fee equal to 33% of the amount sent to the agency and any additional legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance. Your signature below authorizes All Day Medical Care Clinic to release information necessary for collection of past due accounts. Payment in full of any past due balance is expected prior to being seen in our office in the future. In addition, payment in full will be expected at the time of service for any future services.

As protocol, we require a credit card on file for all of our patients with the exception of Medicaid patients. Medicaid patients are exempt from any and all out of pocket fees.

### SELF-PAY

In order to address the needs of our patients without insurance and patients with coverage limitations, we offer a discount off our standard fees. This discount reflects the lower cost involved in billing and collections when a claim does not need to be submitted to a third-party payer. In order to qualify, payment needs to be made in **FULL** prior to the visit.

### INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I UNDERSTAND THAT CERTAIN INFORMATION MAY BE REQUIRED BY THIRD PARTY SOURCES FOR THE PURPOSE OF PAYMENT. I HEREBY CONSENT TO ALL DAY MEDICAL CARE CLINIC RELEASING MY HEALTH INFORMATION FOR THE PURPOSES REIMBURSEMENT. I HEREBY ASSIGN TO THE PRACTICE ALL BENEFITS/PAYMENTS FOR SERVICES RENDERED TO MY DEPENDENTS AND/OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL AMOUNTS NOT COVERED BY MY INSURANCE. MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE BEEN PROVIDED ALL DAY MEDICAL CARE CLINIC'S NOTICE OF FINANCIAL POLICIES.

Printed Name of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Party Financially Responsible/Parent/Guardian: \_\_\_\_\_



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## INSURANCE WAIVER

\_\_\_\_\_(Initial) **Patients who present a new insurance card/new carrier** - I acknowledge that predetermination and/or verification of benefits have not been confirmed with my new insurance carrier. I understand that benefits may not be available and/or the appropriate initial referral/authorization has not been obtained. I assume full financial responsibility for all non-covered charges.

\_\_\_\_\_(Initial) **Patients who present a new insurance card/existing carrier** – I acknowledge that predetermination and/or verification of benefits have not been confirmed with my existing insurance carrier. I understand that benefits may have changed, benefits may or may not be available, and/or the appropriate referral/authorization has not been obtained. I assume full financial responsibility for all non-covered charges.

\_\_\_\_\_(Initial) **Patients requiring referrals** - I acknowledge that I have not obtained an authorized referral from my Primary Care Physician\*. Therefore, I waive the use of my insurance coverage and assume full financial responsibility for all charges incurred today and all future visits without an authorized referral.

\_\_\_\_\_(Initial) **Patients requiring authorization** - I acknowledge that I wish to start testing and/or treatment without first obtaining the necessary authorization. I understand that I am responsible for all charges incurred from this point forward or until authorization is obtained. I acknowledge that there is no guarantee that my insurance company will backdate my authorization for the required dates of service.

\_\_\_\_\_(Initial) **Self-pay patients with or without insurance** - I acknowledge that I have elected to be seen as a self-pay patient. I agree to assume full financial responsibility for all services rendered. Patients that are self-pay must pay prior to the receipt of services.

## OUT OF NETWORK INSURANCE COVERAGE

\_\_\_\_\_(Initial) I understand that I have insurance that may require me to go to physicians or laboratories within my insurance carriers' network of providers. I am aware that All Day Medical Care Clinic may be an out-of-network provider with my insurance plan. I have chosen to continue my treatment with this non-participating provider. I agree to assume full financial responsibility for all services rendered.

By signing this form, I agree to be financially responsible for all services determined by my provider and me to be appropriate. I will resume all costs of services being rendered at the time of services being received.

**In accordance with my understanding of the above, I hereby agree to payment at time of service for all services rendered.**

**Patient/ Guardian (Print):** \_\_\_\_\_

**Patient/ Guardian (Signature):** \_\_\_\_\_

**Date:** \_\_\_\_\_