Primary Care Associates, P.S.
Financial Policy and Consent Form

****Primary Care Associates contracts with Washington Medical Billing, LLC to perform all patient and insurance billing services****

1. Payment is requested at the time of service; this includes but is not limited to co-payments, deductibles, and non-covered services.
2. As a courtesy, we will bill your insurance for you, after your insurance processes you will be billed for any balance that is your responsibility.
3. All balances are due at time of notification. You may pay by mail with a check or credit card.
4. Any account balances unpaid after 60 days will be charged to the Visa or Master card you provided. All card information will be kept secure and used only for this purpose.
5. A finance charge of 1% per month, up to 12% per year is applied on all accounts 60 days past due.
6. We will make every effort to expedite accurate claims to your insurance company for prompt reimbursement, but the agreement of the insurance company to pay for your medical care is a contract between you and the insurance company. The bill remains your responsibility.
7. Missed appointments and cancellations within 24 hours are subject to a $45.00 charge.
8. USE/DISCLOSURE OF PERSONAL HEALTH INFORMATION AND ASSIGNMENT: By signing on the line below this paragraph, you give consent for the doctor, Washington Medical Billing, LLC billing service and the insurance company to use and/or disclose any personal health information required to process your medical claims, perform any required medical treatment or perform required administrative operations. You may refuse to give consent to use and/or disclose your personal health information for treatment, payment and operations, but in so doing, PRIMARY CARE ASSOCIATES may refuse to provide you with treatment services. You have the right to revoke your consent in writing to the extent that the doctor, Washington Medical Billing, LLC billing service and the insurance company have taken action in reliance on your original consent. Furthermore, by signing on the line below you authorize your insurance benefits to be paid directly to PRIMARY CARE ASSOCIATES.

Please sign in the space provided to indicate that you understand the financial policy, use and disclosure of information, and assignment:

Signed: _____ Dated: _____

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