UNION COUNTY
HEALTH DEPARTMENT

NAME OF PATIENT_____

SFS %_____ INSURANCE_____

OUR PATIENT FINANCIAL POLICY

Thank you for choosing Union County Health Department to serve your healthcare needs. We want you to be healthy! The more you know about your health, the better. The following information will help you understand our payment policies and plans. Please read the policy. Ask our staff if you have questions. Then, sign at the bottom.

Insurance

All patients must complete our patient information form before seeing a member of our medical care team. Be sure to use your most recent insurance information. We work with many insurance plans. Not all plans cover all services. If your insurance plan does not cover a service, you are responsible for payment. Please check with your insurance plan to make sure our clinic is in your insurance network.

INITIALS_____

We will file your claims for you. If your insurance company disagrees with your claim, we will provide them with any additional information they need. Your insurance company sets the rates. It is up to you to understand your coverage. You are responsible for payment of any differences.

INITIALS_____

If you have questions regarding your insurance, please ask your human resources representative or ask your insurance company. Their phone number or web address should be on your insurance card.

Co-pays

Some insurance companies ask for co-pays. All co-pays must be paid when you check in for your appointment.

Deductible and Coinsurance

If your insurance company applies any charges to your coinsurance or annual deductible, you must pay those before your next appointment. Any unpaid amounts are also due before your next appointment. Let us know if you need to set up a payment plan. It is up to you to check with your insurance plan about deductibles and coinsurance.

INITIALS_____

High Deductible Health Plans (HSA, HRA, FSA participants)

Let us know before your appointment if you are in a High Deductible Health Plan (HDHP), a Health Savings Account (HSA), a Health Reimbursement Arrangement (HRA) or a Flexible Spending Account (FSA). We can help you figure out if you have any of these. Bring your plan information to your appointment.

We will bill your insurance plan first. If there is any remaining amount, we will send you a bill. The amount on the bill is due before your next appointment. We can help you set up a payment plan if you need one.

Self- Pay Accounts

If you do not have a health insurance plan, receiving services not covered by your insurance plan, or if you have an insurance plan that does not have the Union County Health Department in its network, you must pay for services at your appointment.

Ask our staff if you qualify for our Sliding Scale Fee Schedule or discounts available for cash payments made at your appointment. We can also help you set up a payment plan if you need one.

☐ Referred to Patient Insurance Navigator (no charge for this service).

Payment Details

We accept cash, checks, Visa and MasterCard. We can accept payments over the phone with your debit or credit account information. We may process your payment electronically based on information you provide to us.

There is a $35 fee for returned checks. The amount of the returned check and the $35.00 fee must be paid before you schedule another appointment.

Minor Aged Patients

Minors usually need to be accompanied by an adult. The parent or guardian is responsible for payment of any fees not covered by the insurance plan.

If the adult accompanying the minor is not the parent or guardian, he or she will need written permission from the parent or guardian. We may not treat minors unless we have received this written permission. We can make exceptions to this policy for minors seeking reproductive health services or testing for sexually transmitted infections.

Missed Appointments

If you can't keep an appointment, please call us as early as possible. Our clinics fill up fast, this results in a much later date than anticipated.

Account Delinquency

If we don't receive your full payment in a timely manner, your account may be delinquent. We may refuse future service until we receive payment for your past due balance. Let us know if you are having trouble with payments.

I have read the Patient Financial Policy. I understand and agree to this Patient Financial Policy.

Name of Patient or Guarantor	Signature	Date
Employee Name (Witness)	Signature	Date