



## PATIENT FINANCIAL OBLIGATIONS

Priority Care Clinics, LLC, is in network with the following insurances: Aetna, Carefirst BCBS, Cigna, Medicare, Medicaid, Multiplan, Tricare, John Hopkins, EHP, USFHP, UOM Health Partners, UHC Community Plan, Amerigroup, Priority Partners, Maryland Physicians Care, and United Healthcare PPO plans. Limited coverage may apply to some plans under Coventry, First Health, Coresource, Assurant, Meritain, Great West, Health Partners, Qualcare, and Allegiance. Out of network plans include but not limited to Humana Choice Care, United Healthcare HMO plans, One Net and UMR. All copays or outstanding balances are due prior to receiving services. Every visit is billed, including follow-up visits. For further information, please contact your insurance company.

I, the undersigned, am financially responsible for all charges incurred while a patient at Priority Care Clinics, LLC. I understand that any unpaid charges for "out of network" procedures are the patients responsibility. It is my responsibility, not Priority Care Clinics, LLC, to contact my plan to inquire about my financial obligations regarding non-participating benefits. I agree to pay all costs related to the collection of unpaid balance, including attorney fees, collection costs and interest.

**\*\*\*If your insurance company requires a referral, it is your responsibility to obtain one prior to receiving treatment in this facility. If you do not obtain a referral, you will be responsible for the bill if your insurance does not pay for services rendered\*\*\***

By signing this form, you acknowledge that you may be responsible for additional costs associated with any lab work sent out for testing. These tests will be performed by **LabCorp**. You may decline these tests prior to being drawn or sent out. If the tests are drawn and sent out, you will be responsible for the cost. Priority Care Clinics, LLC, assumes no responsibility for these charges.

Patient Name (please print): \_\_\_\_\_

Signature of Patient or Guardian: \_\_\_\_\_

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