Northland Health Centers

Patient Responsibility Notice

Patient Name: _____

Insurance cards must be presented at time of service or you will be billed for services rendered until insurance cards are received.
Thank you for your cooperation.

NCHC staff will make every effort to assist you in understanding your health/dental benefits. However, it is impossible for us to know all the many different employer group benefits from one employer to the next. Therefore, we are providing this Notice to inform you of the following responsibilities as they relate to benefit coverage and payment responsibilities by the patient and NCHC.

It is my responsibility to know and understand my insurance benefit coverage and limits. I am ultimately responsible for payment of all services rendered by NCHC and must pay for any services not covered by a third party payer.

_____**CASH –** I am aware that I am responsible for all health care bills incurred on my account. I will pay a nominal fee at each visit with cash, check or credit card. All dental fees are due at time of service or a payment plan needs to be established.

_____**MEDICARE –** I understand that NCHC is a participating provider with Medicare. NCHC will bill and receive payment from Medicare for covered services.

_____**GENERAL INSURANCE –** I understand that my insurance policy is a contract between my company and me. NCHC, as a courtesy to me, will submit claims in a timely manner, respond to any written request from my insurance company, and allow up to 30 days for them to pay their portion on my bill. If payment is not received within 30 days of service, I understand it is my responsibility to contact my insurance company to see why payment has not been issued. I will be responsible for the balance at that time. It is also my responsibility to request pre-authorization from my insurance company for treatment, according to my policy. Co-pays need to be paid on day of service.

_____**WORKER'S COMPENSATION (WSI) –** I am aware that NCHC will bill worker's compensation insurance for my work related injury and I am responsible to notify NCHC of my WSI Claim #. I will submit any correspondence received from my insurance company to NCHC. If WSI denies liability for any reason, I understand that I am personally responsible for all health care bills accrued at NCHC.

_____**MEDICAID -** I understand that NCHC will bill Medicaid for covered services. NCHC must be listed as Primary Care Provider (PCP) or proof of referral must be submitted. Co-pays need to be paid on day of service.

I UNDERSTAND THAT THERE IS A TIME FRAME TO FILE ALL INSURANCE CLAIMS. IT IS MY REPSONSIBLITY TO CONTACT THIS OFFICE WITH ANY NEW OR CHANGING INFORMATION ON MY INSURANCE POLICY.

By signing below, I hereby acknowledge and understand my responsibilities as a patient, and authorize NCHC to release all information necessary to secure the payment and benefits from my insurance carrier to our provider and from the insurance company to NCHC when needed. I have read the above and understand that I am responsible for payment of my account according to the above indicated policy that I have initialed.

_____ _____

Patient (or Guardian) Printed Name Date

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Patient (or Guardian) Signature