

New York Walk-In Medical Group, PC
(DR Walk-In Medical Care)

Payment Policy

Thank you for choosing New York Walk-In Medical Group, PC (NYWIMG). We are committed to providing you with the best patient care possible. In order to best serve you and to avoid confusion, please review our payment policy and let us know if you have any questions. Thank you!

Patients with Insurance Benefits: If you have insurance benefits that you would like to use for your visit, please review our policies for in-network and out-of-network health plans.

- **In-Network Health Plans:** NYWIMG currently participates with most major insurance plans, including Aetna, Empire Blue Cross Blue Shield, Cigna, United Healthcare, Oxford, MultiPlan, PHCS, GHI, and HIP, (to see a complete list, please ask our staff). If you are covered by one of these plans or others in which NYWIMG is “in-network”, NYWIMG will submit an insurance claim on your behalf. You will be required to pay your Urgent Care copayment at the time of service (i.e. today). Additionally, we require that you provide us with a valid credit card or debit card authorization to pay for any balances that may remain on your account after your insurer processes the claim or after 30 days. We will attempt to collect the full amount allowable from your insurance plan. However, in the event that there are deductibles, co-insurance, or other amounts for which you are responsible, we will charge your credit or debit card for the remaining balance on your account.
- **Out-of-Network Health Plans:** If you are covered by a health plan in which NYWIMG is “out-of-network” or does not participate, we require that you pay for your charges at the time of service (i.e. today). We will give you a claim form that you can submit to your insurance company to instruct them to send reimbursements directly to you.

Self-Pay Patients: If you do not have health insurance benefits or if you do not want us to file an insurance claim on your behalf, then all charges are due at the time of service.

Acceptable Forms of Payment: For your convenience, NYWIMG accepts Visa, MasterCard, American Express, and Discover as well as cash and checks (U.S. banks only).

I have read and understand this Payment Policy and understand that it is my responsibility to obtain any referrals that may be required by my health insurance plan. I hereby agree to take full responsibility for any and all charges incurred and hereby assign any and all insurance benefits to New York Walk-In Medical Group, PC for services received.

Patient/Guarantor Signature: _____ Date: _____

Patient/Guarantor Name: _____

AUTHORIZATION FOR PAYMENT

In the event that my insurer does not pay all of the medical charges incurred, I hereby authorize New York Walk-In Medical Group, PC to automatically charge the credit or debit card account listed below for the remaining balance due.

Cardholder Signature

Date

Patient Name		
Cardholder Name		
Billing Address		
City	State	Zip
Card Type (Circle One): <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Discover <input type="checkbox"/> Other _____		
Card #	Expiration Date	Security Code

NOTICE

New York Walk-In Medical Group does not send out notification prior to charging credit and debit cards, so please make sure that you have funds available on the above account. You should receive a statement from your insurer indicating the amount they paid and the amount that is your responsibility. If there is a balance that is your responsibility, your credit card or debit card will be charged approximately 3 days after the insurer's statement date. Thank you!

MA's Initials _____

New York Walk-In Medical Group, P.C. (an Urgent Care Provider)

Please update all information, sign, and return to the front desk. Thank You!

Site # _____

Patient Information (all information is required)				
First Name	MI	Last Name	Are you a new patient here?	Referral Source
Email	Gender	Marital Status	Date of Birth	Social Security #
Address		Home Phone #	Cell Phone or Other #	
City, State, Zip		Employer	Payment Method (circle one): Insurance Cash Check Credit Card	
Spouse or Guardian/Guarantor Information				
First Name	MI	Last Name	Relation to Patient	Home Phone #
Address		City, State, Zip		Cell Phone or Other #
Primary Insurance Information				
Insurance Company	ID #	Group #		
Address		City, State, Zip		Phone #
Policy Holder's Name		Policy Holder's Date of Birth		Social Security #
Policy Holder's Employer		Patient's Relation to Insured		Insurance Effective Date
Secondary Insurance Information				
Insurance Company	ID #	Group #		
Address		City, State, Zip		Phone #
Policy Holder's Name		Policy Holder's Date of Birth		Social Security #
Policy Holder's Employer		Patient's Relation to Insured		Insurance Effective Date
Additional Authorized Contact for Billing and Patient Care Issues				
Name		Relation to Patient	Phone #	Alt. Phone #
Consent and Terms of Service				
<p>1. <u>Consent to Treatment</u>: I consent to treatment from the staff of DR Walk-In Medical Care and New York Walk-In Medical Group, PC (NYWIMG).</p> <p>2. <u>Financial Responsibility</u>: I have reviewed NYWIMG's Payment Policy, and I hereby accept full responsibility for all charges incurred. I agree to pay for all charges at the time of service unless NYWIMG agrees to file an insurance claim on the patient's behalf. In the event that an insurance claim is denied or not fully paid by an insurer within 30 days of service, I hereby authorize NYWIMG to charge my credit or debit card to pay for any remaining balance. I understand that it is my responsibility to obtain any referral(s) required by my insurance plan and that outside lab procedures will be billed directly from the outside laboratory and in addition to any NYWIMG fees. I understand that NYWIMG is an Urgent Care provider and Urgent Care copays may apply.</p> <p>3. <u>Assignment of Benefits</u>: I hereby assign all insurance benefits to New York Walk-In Medical Group, PC and authorize payment to be made directly to them.</p> <p>4. <u>Finance Charges and Collections</u>: I understand and agree that if the patient accounts goes unpaid for more than 30 days, it shall incur a finance charge equal to 1.5% per month. I further agree that NYWIMG shall be entitled to recover legal and collection fees from me should the account become delinquent.</p> <p>5. <u>Privacy and Use of Protected Health Information</u>: I have been offered a copy of NYWIMG's Notice of Privacy Practices, and I understand that a current copy of this may be reviewed at any time by visiting DRWalkin.com or by visiting one of the NYWIMG sites during operating hours. I understand and consent that my Protected Health Information may be used in accordance with the Notice of Privacy Practices and that if I wish to request additional restrictions on the use or disclosure of my Protected Health Information, I must make such requests in writing to NYWIMG.</p>				
I consent and agree to the terms as indicated above.				
Signature of Patient or Guardian/Guarantor			Date:	