Family Care
ASSOCIATES
www.familycareassociates.com
1106 N Merchant Street
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Release to Insurance/Financial Policy

All patients are required to show their insurance membership card. A copy will be made for your medical record. Medicaid cards must be presented at *each* visit or the payment is due the day of service. The following information is provided to avoid misunderstanding or disagreement concerning payment for professional services.

1. Our office participates with a variety of insurance plans. It is your responsibility to:
   a. Bring your insurance card to every visit.
   b. Pay your co-payment, co-insurance, or your deductible at each visit. Payment can be made by cash, check, credit, or debit card.
   c. For medical care ***not covered*** under you insurance, payment is due at the time of service.

2. If you have insurance that ***we do not participate in***, our office will file the claim upon request; however, payment is required at the time of service.

3. I give my consent to Family Care Associates of Effingham, S.C. to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all information contained in the patient record of my family members. If I have not made arrangements for payment after 60 days, I will be responsible for all fees incurred for collection and/or attorney fees.

4. The parent, guardian, or unaccompanied minor is responsible for any payment due at the time of service.

5. If you have any questions about your insurance, we will do our best to help you. Specific coverage issues should be directed to your insurance company's member services department. The phone number is located on the back of your insurance card.

I understand that my insurance company requires a co-payment at the time of my office visit. I also understand that it is my responsibility to know the amount of the co-pay and to make this payment to Family Care Associates of Effingham, S.C. by cash, check, credit, or debit card at the time of service. If payment is not made according to the provisions stated above, or within one business day after an office visit, a certified letter may be sent stating that my dependents and I will have 30 days to find a new physician.

Patient's Name	DOB	Patient's Name	DOB
Patient's Name	DOB	Patient's Name	DOB
Patient's Name	DOB	Patient's Name	DOB
Guarantor's Name		Guarantor's Signature	Date