Prima CARE

Billing Department
277 Pleasant St., Bldg. 1, Fourth Floor
Fall River, MA 02721
P: (508) 675-7819
F: (508) 675-3822

Mailing address:
Prima CARE Billing Department
P.O. Box 1029
Fall River, MA 02722

Patient Name: _____ DOB: _____ Account # _____

Patient Financial Obligations

Generally, health insurance covers most of the costs of health care. However, an "insurance co-payment" is a fixed amount of money, determined by the insurance company, that patients must pay for certain health care services. By contract with the insurance company, it is the patient's legal responsibility to pay this amount while the insurance company pays the rest.

1. Co-payment must be paid at the time of service by cash, check, or credit card. If co-payment is not received, that day's appointment may be cancelled and rescheduled.
2. Your claim will be processed through your insurance compan(ies), so you must provide accurate information about your primary and all secondary insurance policies.
3. It is your responsibility to obtain a referral from your primary care physician prior to your specialty visit if your insurance requires one. Without a valid referral, that day's appointment may be cancelled and rescheduled.
4. We will assist you obtaining pre-authorization for any testing or procedures, if required.
5. You are responsible for any additional charges, treatments, or supplies not covered by your insurance.
6. If you fail to make prior payment arrangements with our Billing Department, and your unpaid account balance extends beyond 120-150 days, your account will be turned over to a collection agency. If accounts remain unpaid with no payment arrangements, Prima CARE may not be able to continue providing your medical care and you may be discharged from our group practice.
7. If you have NO insurance, payment is expected in full at the time of service.
8. Patients under the age of 18 years will not be seen unless accompanied by a parent/guardian, or unless we are given signed authorization from the parent/guardian, allowing the Prima CARE team to provide medical care.
9. You are expected to keep all scheduled appointments. Failure to do so without providing 24-48 hour notification may result in a "missed visit" charge ranging from $25.00 - $150.00, depending on the services being rendered. Repeated missed appointments may result in discharge from Prima CARE.
10. A $35.00 fee will be charged for all checks returned due to insufficient funds.

If you have any questions about your financial obligations, please feel free to ask our Billing staff.

I have read and understand my Patient Financial Obligations. By signing below, I agree to comply with this policy.

_____ _____
(Signature of patient) (Date)