SAVING LIVES CENTER FAMILY CLINIC & URGENT CARE
3 HILLCREST DRIVE SUITE A101
FREDERICK, MARYLAND 21703
TEL: 240-575-9940, FAX: 240-575-9481

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment. **THIS IS FOR ALL INSURANCE including Medicare and Medicaid**

- **Please understand that payment of your bill is considered part of your treatment. Fees are payable** before services are rendered. We accept cash, credit cards, debit cards and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable. Co-pays/Co-Insurance payment are part of your treatment and all payment made for services are **NOT Refundable**.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company, we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In- Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I oblige financial responsibility and pay all such charges in full.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

Medical Insurance Information

Insurance name: **Policy Holder's Name:**

Policy Holder's Relationship to Patient

Subscriber OR Member #: **Group #**

Secondary Insurance If applicable

Insurance name: **Policy Holder's Name**

Policy Holder's Relationship to Patient

Subscriber OR Member #: **Group #**

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For ALL No Health Insurance/uninsured, Not Sure if your Health Insurance will cover the visit with the testing, or Out of State Medicaid (not Maryland Medicaid)

PLEASE Sign here _____

Name: _____

Date of Birth: _____ **TODAY'S DATE:** _____

Saving Lives Center Family Clinic COVID-19 SCREENING

PLEASE READ EACH QUESTION CAREFULLY	PLEASE CIRCLE THE ANSWER THAT APPLIES TO YOU	
Have you experienced any of the following symptoms in the past 48 hours: • fever or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or smell • sore throat • congestion or runny nose • nausea or vomiting • diarrhea	**YES**	**NO**
Within the past 14 days, have you been in close physical contact (6 feet or closer for a cumulative total of 15 minutes) with: • Anyone who is known to have laboratory-confirmed COVID-19? OR • Anyone who has any symptoms consistent with COVID-19?	**YES**	**NO**
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	**YES**	**NO**
Are you currently waiting on the results of a COVID-19 test from another facility?	**YES**	**NO**
Have you received your COVID-19 Vaccine? If yes, which one? • Pfizer 1st shot date _____ 2nd shot date given_____ • Moderna 1st shot date given _____ 2nd shot date given _____ • Janssen shot date given _____ • OTHERS_____	**YES**	**NO** **If you would like to take the vaccine please inform us, we have COVID-19 vaccine available at the clinic**

DO NOT WRITE------ FOR CLINIC/MEDICAL STAFF USE ONLY			
TIME:			
TEMP:	**PULSE/HR:**	**RESP:**	**O2 Saturation:**
Covid-19- Rapid: TRIPLEX	**PCR /URI:**	**STREP:**	**Mono:**