Premier Diabetes Care, PLLC

6101 123rd Ave SE Unit B, Snohomish, WA 98290
(425) 318-7144 (800) 516-6570 Fax (949) 404-6552
http://www.premierdiabetescare.com

Consent for Services and Financial Policy

Payment Expectations
Self-paying patients are required to pay in full at the time services are rendered. Insurance copay and deductible are due at the time of service. Account balance is expected to be paid in full within 30 days of the first statement.

Premier Diabetes Care accepts cash, personal checks, and major credit cards. **There will be a $50 service charge for each returned check.**

We require a credit card to be on your file to cover late cancellation and/or outstanding balances.

Insurance Billing
Premier Diabetes Care will bill your insurance through our third-party billing company partner. If we have not received payment from your insurance or your claim is denied, you will be expected to pay the balance in full within 30 days of your first statement.

The credit card we have on file will be charged for any outstanding balances (claim denied, account not pay in full, and other charges) greater than 30 days. We will refund any overpaid amounts upon receiving payments from your insurance company.

Late Cancellation Fee
Appointments must be cancelled or rescheduled at least 48 hours prior to the appointment time to avoid charges. Please note cancelling or rescheduling appointment less than 48 hours will result in a $90 charge for follow up or $125 charge for new patient appointment. Same charges will apply if we show up to your appointment and you are not home (the location you provided) or unavailable. **This fee will automatically be charged to the credit card we have on your file.**

Financial Responsibility
I, the person named above, have read and understand Premier Diabetes Care's financial policy. I agree to assign insurance benefits to Premier Diabetes Care for services rendered.

I authorize Premier Diabetes Care to charge my credit card on file for the above-described charges.

I also understand that if it becomes necessary to collect on this account, I will be responsible for all fees and costs, in addition to the amount owed to Premier Diabetes Care, including reasonable attorney fees and costs incurred in collection, and interest at the rate of 12% per annum on the principal balance owed.

Patient Signature: ____ **Date**: _________________