PrimeCare Clinics

PrimeCare Valley
1581 S 6th Ave
Yuma, AZ 85364

PrimeCare Central
284 W 32nd St
Yuma, AZ 85364

PrimeCare Foothills
11279 S Glenwood Ave
Yuma, AZ 85367

PATIENT FINANCIAL RESPONSIBILITY NOTICE

Patient's Name: _____ Today's Date: _____

Thank you for choosing PrimeCare to serve your medical needs. You are required to read, understand and agree to PrimeCare's statement of Financial Responsibility policy prior to your evaluation and treatment.

Please be aware that you are fully responsible for all services rendered by PrimeCare Clinics, whether or not they are covered by your health insurance. It is your responsibility to know your own insurance benefits, including whether we are a contracted provider, any exclusions of your policy, non-medically necessary/experimental services, pre-authorization requirements, non-urgent, non-covered services, etc. It is your responsibility to provide current, accurate and updated insurance information. If insurance information is not provided at time of services but furnished after the visit, PrimeCare Clinics will submit a claim as long as your claim is within your health plan's claim timely filing. You are responsible of maintaining updated Coordination of Benefits information with your plan, including AHCCCS plans. Failure to do so will make you fully responsible.

Desert Healthcare Services, LLC dba PrimeCare Clinics, does not accept financial responsibility for incorrect information provided by you or your insurance carrier regarding your coverage and benefits.

I, _____, acknowledge that I have been informed of my financial responsibilities. I completely understand and accept full financial responsibility for the total amount due for medical services provided by PrimeCare Clinics. In the event that I have failed to pay for the services provided by PrimeCare Clinics, and the account is placed for collections, I understand and agree that an additional amount equal to 25% of the balance owing at the time the account is placed for collection, will be added to the current balance owing. I agree to pay 10% interest rate per annum until the amount owed is paid in full. I further agree to pay all attorneys' fees and court cost necessary to collect this debt.

Patient's Signature: _____ Date: _____

Name of Parent or Legal Guardian (if minor): _____

Signature of Parent or Legal Guardian (if minor): _____ Date: _____

****This form must be signed by the patient or legal guardian and must be maintained in the patient's medical record****

Revised 09/10/2020