THE WINSTON CLINIC, P.A.

P.O. BOX 100
SHERIDAN, AR 72150
PHONE (870)942-3000 FAX (870)942-3005

Financial Policy

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(PRINT PATIENT NAME AND DATE OF BIRTH)

Thank you for choosing The Winston Clinic, P.A. as your healthcare provide. We are committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all your medical needs are met, our billing department will be available to discuss our fees and this policy with you.

We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to seeing the physician.

Payments for all services will be due at the time services are rendered. In order to serve you better we accept cash, checks, Visa, Mastercard, and Discover. As a courtesy to you, it is the policy of The Winston Clinic, P.A. to bill your insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand:

Please initial each statement below:

_____ Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company.

_____ Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees.

_____ I understand and agree that if I fail to make any payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency by The Winston Clinic, P.A. I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

_____ The above does not apply for those patients that are considered Workers' Compensation. However, be advised that as a compensation patient, you may be held responsible for charges in the event that your claim is disputed.

_____ I understand The Winston Clinic will no longer bill Medicaid or ARKids First as a secondary. I will be responsible for all co-pays, co-insurance, and deductibles. Effective 4/17/18.

_____ I understand if I discuss anything outside of my insurance wellness benefits during my wellness exam I may be charged for a separate office visit.

At The Winston Clinic, P.A., we understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing. If you have any questions, please call (870) 942-3000.

I, _____, agree to the financial policy.

(Guarantor Signature)