Cedar Crest EmergiCenter®
1101 South Cedar Crest Blvd.
Allentown, PA 18103-7902
610-435-3111

Airport Road EmergiCenter®
1791 Airport Road
Allentown, PA 18109-9528
610-264-5844

FINANCIAL POLICY

In order for our office to keep our fees as low as possible, we have adopted the following financial policy. Please read thoroughly and sign. Thank you.

NON PARTICIPATING PLANS - (Those plans that Cedar Crest/Airport Road EmergiCenters do not participate in). The policy of many insurance companies is to send payment to the patient, not the provider. Therefore, we must ask for payment at the time of service.

PARTICIPATING INSURANCE PLANS - As a courtesy to our patients, we will send bills to your insurance carrier. We must emphasize, however, that our relationship is with you, the patient - NOT the insurance company. Therefore, if we do not receive payment from the insurance company in 90 days, the payment becomes the responsibility of the patient. We will send a statement to the patient indicating that the insurance company has not paid the bill. If the bill goes unpaid, the account will go to a collection agency. A collection expense will be charged.

WORKERS COMPENSATION / MOTOR VEHICLE ACCIDENTS - We will send all bills for services to the appropriate insurance company. However, we will ask you to provide information on any other health care coverage that you may have. This may include Blue Shield, Medicare, or other health insurance policies.

CO-PAYS - We are required by contract to collect co-pays at the time of service. Please be prepared to pay the required amount. Visa, American Express, Discover and MasterCard are accepted.

FINANCIAL HARDSHIP - If you are having financial difficulties, it is important that we are aware of the problem, and how long you expect the problem to go on. We will attempt to establish a liberal payment plan. All information will be held in strict confidence.

SELF-PAY - Patients are asked to pay at the time of service.

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RELEASE FOR MEDICARE / INSURANCE PATIENTS

I, the undersigned, authorize payment to be made directly to CEDAR CREST/AIRPORT ROAD EMERGICENTER, for any services provided to me. I further authorize CEDAR CREST/AIRPORT ROAD EMERGICENTER to release to the Health Care Financing Administration and its agents any information needed to determine my benefits and/or benefits payable to the related services.

I understand that my signature requests payment be made, and authorizes the release of all medical information necessary to have my claim paid. If there is a secondary or tertiary insurance company listed, my signature also authorizes the releasing of information to that insurer or agent.

PATIENT AGREEMENT

"I certify that I have read and fully understand the above information. I have advised the physician to proceed with services, whether or not they are covered by Medicare/insurance. If payment is denied, I agree to be personally responsible for payment".

I have read all of the above policies and agree to abide by them.

PATIENTS NAME _____

MEDICARE OR INSURANCE ID # _____

_____ _____
Patient Signature Date

www.CedarCrestEmergiCenter.com