Na'Imah D. Powell, M.D.

Total Care Family Medical Center of Lake Elsinore, Inc.

Main Office
425 Diamond Drive, Suite 105
Lake Elsinore, CA 92530
(951) 674-8779 Fax: (951) 674-1403

Murrieta Office
24703 Monroe Avenue
Murrieta, CA 92562
(951) 698-1168 Fax (951) 698-0768

OUR FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

Payment is due at the time of service unless arrangements have been made in advance. Cash and Credit Cards are accepted. **Sorry, No Checks**.

Please keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claims if you assign benefits to us - in other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we receive a check from your insurance at a later date, we will refund any overpayment to you.

We have contracts with many insurance companies and other health plans to accept an assignment of benefits. We will bill your insurance; however you are required to pay your deductible and/or co-payment at the time of your visit. We do the best we can to collect the correct amount from you. We verify your insurance benefits but sometimes we are given incorrect information. We do not know for sure until the Explanation of Benefits (EOB) is received from your insurance company. You may receive a bill or refund from our office at a later date.

If you are seen in the Urgent Care, there is a possibility of additional charges for after hours care.

Not all insurance plans cover all services. In the event your insurance plan determines a service "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice upon annual review.

_____ _____

Signature of Patient (or Responsible Party, if minor) Date

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Please Print Name

There may be a charge for NO Show Appointments. Please cancel 24 hours in advance.