



Scioto Urgent Care

4760 Sawmill Rd.

Ph: 614-789-9464

Columbus, OH 43235

Fx: 614-789-9575

Notice of Privacy Policy and Financial Policy

Scioto Urgent Care is committed to providing you with the best possible care. If you have insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our policies and practices.

Payment for services is due at the time services are rendered.

If you have insurance, a current insurance card and any copay is due at the time of service. We will be happy to process any insurance claims for you and we accept insurance assignment with our in-network providers. At this time our in-network providers are as follows: Aetna, Anthem Blue Cross and Blue Shield, Bureau of Workers Compensation (BWC), Medical Mutual of Ohio, Medicare, OSU Prime Care, Unicare, and United Health Care. For out-of-network insurance, we require a \$50 deposit. Your ultimate responsibility is based on your insurance provider's out-of-network urgent care benefits.

Ultimately, your insurance is a contract between you and your carrier. We are not a party to that contract. Any service that is not covered by your insurance company, for whatever reason, is your responsibility.

For self-pay patients seeking a basic office visit, a \$135.00 fee is required at the time of your visit. For any additional procedures (xrays, sutures, lab work, etc) there will be an additional fee, required at the time of service. Please ask our front desk staff for these prices.

I hereby acknowledge that I _____ have read this document and understand my financial responsibility for services provided for myself, and other patients whose names I have provided to appear under my responsibility with Scioto Urgent Care, and the office staff has informed me that if I will be providing an insurance today, whether or not Scioto Urgent Care is in my insurance network, and have received a copy of the Notice of Privacy Practices on this day ___ / ___ / ___.

Patient or Guardian's Signature _____ Date _____