Texas Family Medicine

Board Certified Family Physicians

FINANCIAL POLICY AGREEMENT

Thank you for choosing Texas Family Medicine for your family's medical care. We are committed to providing you with quality, personal health care. We appreciate your commitment to adhere to this Financial Policy Agreement. To reduce confusion or misunderstanding we ask that you read this Policy, ask any questions, and sign the Acknowledgement section at the bottom of this form. Other than for true medical emergencies, agreement with this policy is required for all medical care.

Payment is required at the time services are provided unless other arrangements have been made in *advance*. We accept cash, personal checks, and VISA, MasterCard, Discover, American Express & Care Credit. There is a $35.00 service charge for returned checks. You may also make payments online through the patient portal.

INSURANCE: We participate in most managed care plans and will bill your insurance plan as may be necessary. If we do not participate with your managed care plan, payment in full is required at the time of service. If you are without health insurance and you are enrolled in the Jefferson Independence Card (www.jeffersonicard.com) your payment may be substantially reduced at the time of service! Knowing your insurance benefits – including eligibility, covered benefits, and medically necessary procedures is *your* responsibility; please contact customer services at your insurance company for questions you may have regarding your coverage. ***You are responsible for any services not covered by your plan***.

- **Proof of Insurance**. All patients must complete and/or update our Patient Information Form at each office visit. You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to the time of service. Insurance denials for termination of coverage will be automatically billed to you.
- **Co-payments and deductibles**. All co-payments, deductibles and co-insurance must be paid at the time of service. Protection of your insurance benefits requires us to charge for, and you to pay for, all required co-payments, co-insurances, deductible and non-covered services.
- **Claim submission**. We will submit your insurance claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner. Texas insurance law requires your insurance company to provide timely payment. Please be aware that the balance of your claim is your responsibility to pay whether or not your insurance company has paid. We are not a party to your insurance contract.
- **Referrals**. If your managed care plan requires approval or authorization for referrals to a specialist, radiological imaging, medical facility care, *etc*., it is *your* responsibility to inform the office of this requirement *prior to* referral. We require 48 hours notice to facilitate a referral request and cannot issue retroactive referrals.

SELF PAYMENT: Texas Family Medicine recognizes that some of our patients may be without insurance coverage. Therefore, we are a participating provider for the **Jefferson Independence Card** program. To learn more, and to obtain similar discounts on other health care services, please visit **www.jeffersonicard.com**.

OTHER SERVICES, CHARGES AND PATIENT RESPONSIBILITIES: Insurance coverage generally does not include coverage for many administrative services, such as requests for information and form completion. ***The following services may have an administrative service charge that will be billed directly to you and are your responsibility for payment.*** Our practice is committed to providing the highest quality of service to our patients while keeping our charges for administrative services at or below the usual and customary charges of other medical practices in our area. All such administrative fees must be paid prior to scheduling future appointments.

- **Missed appointments**. Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time set aside for you. We require 24 hour notice of cancellation to avoid a cancellation fee. ***Please note that we require 48 hour notice of cancellation for echo and stress echo appointments.*** The fees are detailed below. It is your responsibility to remember your appointment.
  **** $25.00 for office visits * $50.00 for physicals or procedures * $250.00 for echo or stress echo***
- **Prescription refills**. New prescriptions will not be issued without first seeing your physician. Prescriptions for acute care or chronic conditions are usually written with an appropriate number of refills to complete the course of treatment or to last until your next scheduled appointment. These do not require further approval for refills. Consult your pharmacist as needed. ***To request a refill, please contact your pharmacy first.*** These requests will be handled between 8:30 A.M. and 3:00 P.M., Monday through Friday. Any refill request after 3:00 P.M. will be handled on the next business day. Please allow 48 hours for prescription refills.
- **Form completion**. All forms requiring medical review and physician signature – including school, day care, and camp physicals, prior authorizations, FMLA, disability or other paperwork – may be subject to an administrative fee of $30.00. Administrative fees may be waived if the patient has a scheduled appointment in conjunction with forms completion.
- **Requests for medical records**. Texas Family Medicine requires written requests for the release of medical records. The administrative fee associated with copying medical records is based on current Texas law, which allows up to 15 business days to release the requested copies to you. Please take this into consideration when requesting copies of your medical records.
- **Care for minors**. A parent or legal guardian ***must*** accompany minor patients on the patient's first visit. The accompanying adult is responsible for payment of the account, according to the policy outlined above. Please note that we will not administer injections of any kind without a parent or guardian present.
- **Delinquent accounts**: Statements will be mailed for outstanding balances. If more than one statement is mailed in an attempt to collect an outstanding debt an administrative fee may be assessed. Delinquent accounts will be submitted to an outside collection agency. If your account is transferred out of our office for collection, you will be responsible for all fees incurred by Texas Family Medicine to collect your outstanding debt.
- **Returned checks**: Returned checks will incur a fee of $35.00. If more than one returned check is received on your account, we will require all future payments be made by cash, cashier's check or credit card. Any checks that are not paid will be filed with the District Attorney's office for collection. All fees incurred in the filing will be your responsibility.

All patients are required to acknowledge their understanding of and agreement to comply with this Financial Policy Agreement by signing the Acknowledgement section at the bottom of this form prior to establishing care with Texas Family Medicine. Except for emergency care, patients may be denied services for their failure to agree to this Financial Policy.

Thank you for understanding our financial policy. Please let us know if you have any questions.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Texas Family Medicine.

I authorize Texas Family Medicine to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

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Date **Signature** **Printed Name**