

PATIENT FINANCIAL POLICY

Date: _____

Account # _____

Prepared for: _____
(Patient or person financially responsible for payment of the Clinics of North Texas, LLP bill)

Patient Name: _____ DOB: _____ HIST #: _____

Dear Patient,

Thank you for choosing the *Clinics of North Texas, LLP* as your healthcare provider. We are committed to providing you the highest quality, most affordable healthcare service available. In order to do so, we have established the following Financial Policy which we request you to read, agree to and sign before services are provided. A copy will be provided to you upon request.

Payment Policy: It is our policy that payment for services are due in full at the time service is rendered. Acceptable means of payment are cash, check, money order or credit card. We do not generally offer extended payment plans.

Your Responsibility: If you have insurance please understand **this is an agreement between you and your insurance company to pay certain amounts for certain types of medical care.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit.

Proof of Coverage: At the time of service, you must provide a copy of your most recent insurance card (s) and a photo ID to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If your insurance changes, please notify us before your next visit so we can make appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Claims Submission: With most types of insurance, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. It is your responsibility to comply with any request for information your insurance company may need from you. After your insurance pays the contract amount, we will notify you of any remaining deductible, coinsurance, or non-covered patient responsible balance.

Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Non-covered services: Please be aware that some-and perhaps all-of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Non-Payment: Any balance is due in full and may be paid by one of our payment options listed above. If your account balance becomes past due without satisfactory payment arrangements, the policy of **Clinics of North Texas, LLP** is that past due accounts may be reported to the credit bureau and/or turned to a private collection agency. Finance charges will be assessed to balances that are 90 days past due.

ASSIGNMENT OF BENEFITS: I hereby authorize payment of benefits be made directly to *Clinics of North Texas, LLP* for services provided me by *Clinics of North Texas, LLP*. I understand that I am financially responsible to *Clinics of North Texas, LLP* for charges not covered by this agreement. I authorize refund of overpaid insurance benefits where my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.

Again, thank you for choosing *Clinics of North Texas, LLP* as your healthcare provider. Just as your physician and medical staff are always available to provide you quality medical service, your patient account specialist is available at any time to assist you with any financial matters.

“I have read, understand and agree to the provisions of this Financial Policy.”

Signed: _____
(Signature of person financially responsible for payment of the *Clinics of North Texas, LLP* bill)

PLEASE COMPLETE THE PATIENT FINANCIAL INFORMATION ON THE BACK OF THIS FORM

PATIENT INFORMATION:

SSN _____

Name _____
First Name MI Last Name

Cell Phone# _____

Address _____
Street Apt #

Phone _____

City State Zip Code

Birthdate _____

Employer _____

Phone _____

Primary Care Physician _____

GUARANTOR INFORMATION:

SSN _____

Name _____
First Name MI Last Name

Cell Phone# _____

Address _____
Street Apt #

Phone _____

City State Zip Code

Birthdate _____

Employer _____

Phone _____

Address _____
Street Apt #

Phone _____

City State Zip Code

INSURANCE COVERAGE:

Primary Insurance Co Name Co # Policy # Plan # Group #

Name of insured person Relationship to Patient Effective Date

Address to send claims: Phone#

Other Insurance Coverage _____

Emergency Contact _____ Relationship _____

Address _____ Phone _____

WE REQUIRE A COPY OF YOUR INSURANCE CARD AND PHOTO ID BEFORE SERVICE CAN BE PROVIDED