

**Conroe Physician Associates
508 Medical Center Blvd
Suite 200, Conroe, TX. 77304
Tel: (936) 760-4600**

OUR FINANCIAL POLICY

Welcome to our office! Thank you for choosing us as your Healthcare Provider. We are committed to providing you with the highest quality of health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

- 1. Insurance:** 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 prior to each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full prior to each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.**
- 2. 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. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
- 3. Non-covered services:** Please be aware that some and perhaps all of the services you receive may be **non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.**
- 4. Proof of insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card 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.
- 5. Claims submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.** Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the 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.

7. **Non-payment:** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular mail that you have 30 days to find alternative medical care. During the 30-day period, our physician will only be able to treat you on an emergency basis.

8. **Missed appointments:** Our policy is to charge **\$25.00** for missed appointments not canceled 24 hours prior to your appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment.

9. **Fees for procedures missed appointments; shall be \$50.00.**

10. **There is a \$25.00 handling fee for non-sufficient (NSF) checks.**

11. **There will be a charge of \$5.00 for lost or misplaced prescriptions, radiology and lab orders. There will also be a charge for disability forms not covered by your insurance.**

12. **Minimum of \$5.00 for credit card charge.**

13. **There will be a fee of \$3.00 if you request a refund after a charge has been made to your credit card.**

14. **There will be \$1.00 charge per page for copies of medical records.**

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date