NORTH TEXAS
ENDOCRINE CENTER

PAYMENT FINANCIAL POLICY

It is important that we have good understanding with our patients regarding financial responsibility. We hope this summary will be helpful toward that end. We encourage you to discuss it with us and ask questions if necessary.

Insurance:
We participate in many major insurance plans, including traditional Medicare. If you are not insured by a plan we do business, payment in full is expected at each visit. If you are insured by a plan, we do business with, but you cannot provide us with an up-to-date insurance card, payment in full for each visit is required at the time of service. Please contact your insurance company with any questions you may have regarding your coverage. Knowing your insurance benefits is your responsibility.

Insurance Authorizations and Referral:
We bill insurance as a courtesy to our patients. Patients are responsible to know their insurance coverage as well as responsible for the bill. You are responsible for obtaining all **referrals and authorizations** prior to your office visits. You will be responsible for all charges not covered by your insurance company. Please contact your insurance company with any questions you may have regarding your coverage. Knowing your insurance benefits is your responsibility.

Private Pay (Self Pay):
Payment is due at the time of service unless previous payment arrangements have been made. We offer a discount for all private pay patients paying in full at the time of service.

Copayments, Co-Insurance and Deductibles:
All co-payments, co-insurance amounts and deductibles must be paid at the time of service unless other arrangements have been made. Copayments are a part of your contract with your insurance company.

Non-Covered Services:
Please be aware that some of other services you received may be non-covered or not considered reasonable or necessary by your insurance. You will remain responsible for amounts and any services that are not covered by your insurance company. Knowing your insurance benefits is your responsibility.

Claim Submission:
After your appointment, we will submit a claim to your insurance company. We will help you in any way we reasonable can to get your claims paid by the insurance company upon request. Please be aware that any remaining balance of your claim not paid by the insurance company is your responsibility. If your insurance carrier has not paid our claim within 90 days, we will expect payment from you. Please contact your insurance company with any questions you may have regarding your coverage. Knowing your insurance benefits is your responsibility.

Cancellations and Missed Appointments:
Existing patients who miss an appointment or cancel less than 24 hours of notice will be charged a **cancellation fee of $50.**
New patients who miss an appointment or cancel with less than **48 hours of notice will be charged a cancelation fee of $75.00.** These fees must be paid before another appointment can be scheduled.

Acceptable Forms of Payment:
For your convenience, we accept payment by cash, check (with valid driver's license), Visa, MasterCard, Discover and American Express.

Responsibility Statement:
Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on our contract with them. It is your responsibility to pay the deductible, co-insurance, and other balances not paid by your insurance company. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill. It is also your responsibility to inform the office anytime there is a change in your insurance coverage. **To ensure good billing practices, you will be asked to present a copy of your current insurance card and picture identification at each visit**. **On-Medicare Patients:** I authorize the release all medical information necessary to process my claims. I assign all medical and/or surgical benefits, including major medical benefits for which I am entitled, to North Texas Endocrine Center and its physicians. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. **Medicare Patients:** I authorize any holder of medical information about me to be released to health care financing administration and its agents any information needed to determine benefits or benefits payable for related services. This assignment is to be considered in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.
I have read and understand the Payment Policy and Responsibility Statement as written above. I agree to financially responsible for all Charges.

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