

## Medical Services Financial Agreement

Thank you for choosing Lone Star Allergy & Asthma Center for your health care needs. It is our hope that the following financial policies will be helpful and reduce misunderstanding or confusion as we pursue payment for the medical services we provide. Please speak to a receptionist if you have any questions regarding these policies.

### PAYMENT FOR SERVICES

Payment for services is due at the time services are rendered. Payment-in-full is due for all private pay patients at the time of service unless other arrangements have been made with our office in advance. For patients with insurance, such payment includes any co-payment, deductible, co-insurance, and all fees associated with non-covered services. Failure to collect these payments may be a violation of our contract with your insurance company. We accept cash, checks, money orders, Visa, MasterCard, Discover Card, American Express and most debit cards. Returned checks will result in a **\$25** administrative fee that will be posted to your account. Please make every effort possible to avoid account delinquency. Delinquent account balances will be assessed a **\$20 late fee** every 30 days from the initial statement date. Delinquent account balances older than 60 days will be subject to a collection service fee of **40% of all outstanding balances** plus additional collection fees including but not limited to attorney and other court fees.

### MEDICAL INSURANCE

If we are contracted with your medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this, you must provide our office with personal information, including copies of your health insurance card and drivers license. It is your responsibility to make sure we have your current information on file prior to receiving care. This information will be used to verify your insurance benefits. If you are unable to provide complete insurance information for benefit verification, you are responsible for full payment at the time of service. If payment is subsequently made by your medical insurance, you will be reimbursed any overpayment on the account.

Some insurance companies arbitrarily select certain services they will not cover. We will make every effort to notify patients before rendering any non-covered service. This notification may occur via the telephone or by signing an “**Advanced Beneficiary Notice**” before your scheduled appointment time. In such cases, we will gladly discuss with you the fee for a particular non-covered service. If you choose to receive the non-covered service, full payment is expected at the time of service.

As a courtesy to our patients, we will gladly submit a claim for a covered medical service to the insurance company. However, we cannot guarantee payment of your claims as the insurance company will only “quote” benefits, they never “guarantee” benefits. Please understand that the ultimate responsibility for ensuring complete payment is made lies with you, not your insurance company. If your insurance has not paid a claim within 30 days of filing a clean claim, any unpaid professional fees are due and payable in full from you within 30 days of your statement date. If payment is subsequently made by your medical insurance, you will be reimbursed any overpayment on the account. Likewise, once insurance pays a claim, any remaining balance deemed to be the patient’s responsibility, are due and payable in full within 30 days of your statement date.

Your health insurance is a contract between you, your employer (if applicable), and the insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.

## REFERRALS & CONTRACTED FACILITIES

If you have an insurance plan that requires a referral (e.g., an HMO plan), it is your responsibility to obtain a referral from your primary care provider prior to your first scheduled appointment and keep it current for every visit thereafter. If we do not have a referral, services can only be rendered if you sign an “**Advanced Beneficiary Notice**,” stating that you understand that a referral was not obtained and payment in full is expected the day of service. If you require the use of a specific lab or x-ray facility, you must notify the nurse to ensure the proper facility is used.

## CANCELLED APPOINTMENTS

Missed appointments represent a cost to us and to other patients who could have been seen in the time that was set aside for you. Therefore, cancellations must be requested at least 24 hours prior to the scheduled appointment time. Failure to cancel or show for a scheduled appointment may result in a **\$25** administration fee. Failure to cancel or show for a scheduled procedure may result in a **\$50** administrative fee. These fees are not billable to your insurance.

## MEDICAL RECORDS

We are dedicated to keeping your medical records confidential and therefore require written authorization for release of medical records. Requests for medical records will be processed within 15 business days as mandated by the Texas Board of Medical Examiners and will be subject to a processing fee as determined by the Texas State Medical Board.

## MEDICATION REFILLS

Please call your pharmacy to request a refill of your medication(s). Prescription refills may take 48 hours to process. Routine refill requests will not be honored if the patient has not been evaluated by their physician within the past 12 months. However, urgent refill requests will be honored with the understanding that the patient must be evaluated by their physician before another refill is required.

## GENERAL

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding your insurance coverage or benefits, please do not hesitate to speak to one of our receptionists about your concerns. Thank you.

### **Acceptance of the Medical Services Financial Agreement**

I have read and understand the Medical Services Financial Agreement above and all questions that I have concerning this agreement have been answered to my satisfaction.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient, Parent or Legal Guardian