Mt. West Family Health Center
V.M. Villalobos, M.D. • Board Certified Family Physician

PRIORITY AFTER HOURS CLINIC

PATIENT FINANCIAL AGREEMENT

Our medical practices understand that the cost of healthcare is a key concern for our patients. Our goal is not only provide you with superior medical care but also to provide you with the highest quality billing & insurance support. In return, we hope that you assist is by understanding your responsibility as it relates to our Financial Policy. If you have any questions regarding our policy, a representative of our staff will be glad to assist you.

PAYMENT REQUIREMENTS FOR ALL PATIENTS
You are responsible for paying in full **AT THE TIME OF SERVICE** all your portion of deductibles, co-payment, co-insurance, and all services and supplies that are not covered by your insurance including denied or services deemed not medically necessary. Payment will be collected prior to rendering services at patient check-in. **You must notify us immediately if you are not able to make payment in full.**

New patients to our practice may be asked for a $150 deposit at the time of check-in to be applied to their first visit.

By signing this form, you have authorized our office, along with, its providers and its employees, agents and assignees to contact you via e-mail, text messaging and to your cellular devices.

Patient Information: It is your responsibility to ensure that we have current and accurate patient demographic data and insurance information for each and every visit. Please make sure that we have correct information prior to seeing one of our medical providers at each visit. Please be sure to bring your insurance card & a photo ID at all times.

Minor Patients: The adult accompanying a minor & the parent (or guardians) of the minor are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit card, or payment by cash or check at the time of service has been verified.

Patients with Insurance: Please note that your insurance policy is a contract between you & your insurance company. We are not party of that contract.

We charge what is usual and customary for our area, regardless of the insurance company's arbitrary determination of usual and customary rates.

Our office participates with numerous insurance. For patients that are members if these plans, our business office will submit a claim for services rendered. You are responsible for:

- Know your benefit coverage, as well as your dependants, prior to receiving services. Please contact your employer or insurance company with any questions you may have regarding your coverage including specific coverage issues (number is on the back of your insurance card or please contact your employers Benefit Office with questions).
- Your insurance company may request additional information for your visit. Be sure to complete and submit, since failure to comply will result in your insurance not paying benefits on your behalf, and the outstanding balance will immediately be due in full.
- Paying in full AT THE TIME OF SERVICE if we are unable to verify proper insurance coverage. If you chose to use a credit care as a form of payment, we will only preauthorize payment. A charge will be made only for your portion once confirmation has been received by your insurance.
- Services rendered by a third party when specified by your insurance in order to reduce medical expenses on your behalf.
- Your insurance company may require two (2) co-payments for the same day of service. This generally can occur when you are treated for acute or chronic conditions on the day that you have come in for your annual exam.

The Texas Clean Claims Act (HB 610) established that insurances (in general) have a 45-day statutory claims processing period. Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. Therefore, if you fail to receive and Explanation of Benefits (EOB or EOP) from your plan within 45 days of treatment, contact your insurance plan to determine benefits, as they may not have made a payment.

Payment not received in 60 days may be transitioned which will make you immediately responsible for the full outstanding payment.

Assignment& Release: **By signing this form, you have** authorized us to furnish to your insurance company(ies) or their representatives information concerning your illness or treatments. You hereby assign the payment of your insurance benefits to us for medical services rendered. You have also been made aware and understand that you are responsible for any amounts not covered by your insurance.

Non-Medical and Other Service Fees: Please note, we do not provide any time of payment arrangements or discounts for services listed below. We charge for the following non-medical services (we reserve the right to increase fees at any time without notice).

Completion of Forms: Any form requiring the signature of one of our medical providers will result in a service fee ($35- $149). Regardless if you completed this form yourself, under no circumstances will this fee be waived. The medical provider is liable for medical accuracy, and therefore in order to ensure that we review the information properly please note that we may take in access of 10 days upon receiving payment before being able to complete your request.

Customized Letters: Any customized letter requiring he signature of one of our medical providers will result in a service fee ($75). We cannot accept pre-generated letters nor will we be able to provide signature on these types of letters. Furthermore, under no circumstances will this fee be waived. The medical provider is liable for medical accuracy, and therefore in order to endure that we review the information properly please note that we may take in access of 10 days upon receiving payment before being able to complete your request.

Medical Records: ($35) under no circumstance will this fee be waived. The medical provider is liable for medical accuracy, and therefore in order to ensure that we review the information properly please note that we may take in access of 10 days before being able to complete your request. Payment must be received prior to us generating copies of medical records.

Missed Appointments: Please notify our office 24 hours in advance if you are unable to keep your appointment. Failure to do so will result in a $35.00 no show fee, and $ 125 for sleep studies

We encourage that you meet all your financial obligations with us in order to prevent the following additional fees:

Returned Checks: There is a fee of $35.00 for all returned checks. **By signing this form, you have** authorized us to electronically withdraw this fee along with the original intended amount processed.

Late Payment Fees: Any account with a balance over 30 days without any payment will incur a $5 per month billing charge.

Past Due Accounts: Any past due balance not paid will be turned over to collections after 90 days & will incur collections costs.

Third Party Collection Fees: You will receive statements at eh address you provided to us with the balance on your account. We strongly encourage that you make payment arrangements with our billing department to discuss payment options, before your account becomes overdue. Delinquent accounts may be assigned to a collection agency. Along with a $25.00 processing fee, all collection costs will be added to your outstanding balance and will become an additional cost to you. We will not be held responsible for any collection agency fees.

Credit Cards on File and recurring Payments: Our office is capable of keeping your card on file and handling recurring payments or any unpaid portion of your insurance company. We will be happy to arrange this in order to minimize any potential incurring costs to you.

Disclosure: Providers are not authorized to discuss financial issues. Our billing staff is trained to discuss your account & will be happy to help you. Any payment exceptions will be agreed upon in writing.

I have reviewed, understood, and agree to all the statements within this Patient Financial Policy.

_____ _____

Patient's Name (PLEASE PRINT) Date

_____ _____

Responsible Party's Signature Date