



PHYSICIANS' CENTER, P. A.
Family Medicine & Minor Emergencies

Financial Policies

We would like to thank you for choosing Physicians' Center, P.A. as your medical provider. To keep you informed of our current office and financial policies we ask that you read and sign our financial acknowledgement prior to any treatment. Please keep this document for future reference.

Credit Card Policy

We would be more than happy to keep a credit card on file if you would like to make all your charges with us under your credit card. If so please ask the front office for the proper form to fill out. We accept Visa or Mastercard

Canceled Appointments

If you are unable to keep your scheduled appointment, please call our office within 24 hours to reschedule your appointment. This will enable us time to use your appointment time for another patient. There is a **\$35.00 NO SHOW FEE** if you do not call and cancel prior to your appointment time (24 hours).

No Insurance

Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our Financial Coordinator.

Insurance

Please bring your insurance card with you at the time of your appointment. For insurance plans that we contract with, your carrier requires that all co-pays be paid for any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. You are responsible for any co-insurance, deductibles, co-pays and/or non-covered services as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Any remaining balance is due upon receipt of that statement. Outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments

Managed care

You must receive a referral from our office before seeing a specialist. No retroactive referral will be given. You must receive a referral from your PCP before services can be rendered by this practice.

Auto Accident Injury/ Liability Injury

If your injury is due to an automobile accident, we request that you provide us with any information that will assist us in getting your medical claims paid. This information may include: copy of police report, copy of auto insurance, medical insurance, names and information of other parties involved. We are not responsible for any and all attorney fees/charges/payment plan. We will bill your health insurance or you may pay cash for your visits.

Workers' Compensation

If your injury is due to an accident in your work place, please be sure to contact your employer and inform them of your injury. We will need to receive authorization from your employer before we can process any of your medical claims. Please have your employer contact our Workers' Compensation Department at 512-869-7310 ext. 253. Failure to properly report this injury to your employer may result in your claims being denied. Denied claims will be your responsibility.

Return checks

A \$30.00 charge will be added to your account for any check returned by your bank for any reason, plus the amount of the check. If you do not take care of this outstanding balance within a reasonable time, it may cause grounds for dismissal from our clinic.

Disability or Insurance Forms

There will be a charge of \$15.00-\$35.00 for the completion of medical forms (charge is based upon number of pages and complexity of information requested). Payment is due at the time that you pick-up the forms. Please allow 7-10 days for us to complete your forms. If you wish for your forms to be mailed, there may be an associated fee to cover the mailing costs. Rates charged are within Texas State Statutes.

Patient Name: _____

Patient Financial Responsibility

I acknowledge full financial responsibility for services rendered by Physicians' Center, P.A. I understand that I am responsible for prompt payment of any portion of the charges not covered by my insurance, including coinsurance, deductibles and copays. I understand payment of co-pays is expected at time of service, as well as any prior balance I may owe. I also consent that the payment of authorized medical insurance benefits be made on my behalf directly to Physicians' Center, P.A. for any medical services rendered. I agree to all reasonable attorney fees and collection costs in the event of default of payment of my charges, as outlined in office and financial policies guidelines.

Signed _____ Date _____

Consent for Purpose of Treatment, Payment and Healthcare

I hereby give my consent to Physicians' Center, P.A. to use or disclose, for the purpose of carrying out treatment, payment or healthcare operations and all protected health information contained in the patient record. For more detailed description of the consent and other uses and disclosures please review our Notice of Privacy Practices. I understand that Physicians' Center, P.A. reserves the right to change its privacy practices that are described in this notice. I understand that this consent is valid until it is revoked by me. I understand I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed _____ Date _____

Acknowledgment- Notice of Privacy Practices

I hereby acknowledge receipt of Physicians' Center, P.A. Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential health information. I understand that Physicians' Center, P.A. has reserved the right to change its privacy practices that are described in the notice. I also understand that a copy of any Revised Notice will be provided and made available to me.

Signed _____ Date _____

If you are not the patient, please specify your relationship to patient _____