GEORGETOWN MEDICAL CLINIC

3201 SOUTH AUSTIN AVENUE, SUITE 210 ✦ GEORGETOWN, TEXAS 78626

FINANCIAL POLICY

We appreciate payment at the time of service and will accept personal checks, VISA, MasterCard, American Express and Discover. Prompt payment helps keep both our costs and fees down. Payment will be collected at the time of arrival and you will receive receipt of your payment or insurance co-pay and any insurance forms that you may need.

Our Physicians share your concern about the cost of medical care. We strongly believe that the best medical service is based on a friendly, mutual understanding between doctor and patient. We therefore invite you to discuss frankly with us any questions you may have regarding our services or fees. If you anticipate problems with your insurance coverage or personal payment, you are encouraged to contact our financial counselor. The earlier we know about a possible problem, the better we are able to develop suitable options for you.

AGREEMENT

This is an agreement between Georgetown Medical Clinic, as provider and creditor, and the Patient named on this form. By executing this agreement, you, Patient, are agreeing to pay for all services that are received.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. All balances are expected to be paid in full upon receipt of this statement. Payments not received within 15 business days of receipt of statement are considered past due and could be subject to late fees or interest penalties.

PAYMENT OPTIONS IF YOU HAVE NO INSURANCE:

A. An advance deposit of $135.20 is required prior to your first visit (Note: Annual exams require a larger deposit). You may pay by cash, check, or credit card. Any remaining balance will either be refunded or credited towards future services according to your wishes.
B. For extensive services such as deliveries you may prefer to secure a loan from your financial institution or credit union. You are invited to discuss this with our Financial Department in advance of service.

PAYMENT OPTIONS IF YOU HAVE INSURANCE:

A. You must pay all deductibles, co-pays, and co-insurances in full at time of service. You may choose to pay with cash, check, or credit card.
B. You may choose to pay for all services in full and file with your insurance company.
C. Patients must pay co-pays or deductibles before surgical procedures are performed and at the time that office services are rendered, if there is no insurance carrier contract provision to the contrary.

INSURANCE: Insurance is a contract between you and your insurance company. We will bill your primary insurance if you have provided correct information. Although we may estimate what your insurance company may pay, the insurance company makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If the insurance does not pay within 60 days from the time services are rendered, the balance may be billed to you.

REQUIRED CO-PAYMENTS: Any **co-payment** required by an insurance company **must** be paid at the time of service by contract. We cannot bill you for these fees.

RETURNED CHECKS: There is a fee of $25.00 for checks returned by the bank. If a returned check is received on your account you will be required to pay all fees associated with this check. All future visits will need to be paid in cash prior to being seen.

MISSED APPOINTMENTS: When a patient does not show for an appointment or cancels with less than 24 hours notice, the patient may be subject to a $35 fee for routine appointments and an $80 fee for extended appointments (physical exam, procedure). This fee would be due prior to scheduling a new appointment.

Good medical care requires a mutual relationship of trust, confidence and respect. Persistent failure to keep scheduled appointments may result in dismissal from the practice.

PAST DUE ACCOUNTS: If your account becomes past due, we will take necessary steps to collect this debt. If we are forced to refer your collection balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Williamson County, Texas.

DIVORCE: Consistent with Texas statute, in case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. **If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.**

ACCOUNT SUMMARY FEE: For printed Account Summaries for the most recent calendar year (flex plans, income tax, court purposes, etc.,) there is a $5.00 fee for each account.

WORKERS COMPENSATION: We do not provide treatment for work-related illness/injury. If you do not disclose your visit is job related, you are financially responsible for all charges incurred for that visit.

PERSONAL INJURY/MVA: We do not bill attorneys for medical services. Any services performed in relation to a personal injury case must be paid in full at time of service.

PHYSICALS: There is a $35 fee (est. patient) $75 (new patient) for sports, college or camp physicals. This is not a covered benefit by most medical insurance plans.

DISPUTES: You should notify us of discrepancies in writing immediately. We will investigate and resolve your dispute within 30 days.

ADDITIONAL SERVICES: Please be aware that there are fees for additional services such as prescriptions rewrites, copying medical records, depositions and special forms. Please check with the Financial Department for specific fees for additional services.

Patient Name

Responsible Party (if not patient)

Signature

Date

Georgetown Medical Clinic

PATIENT NAME____DATE OF BIRTH____________

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

Financial Agreement.

- I acknowledge, that as a courtesy, Georgetown Medical Clinic may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

Third Party Collection. I acknowledge that Georgetown Medical Clinic may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.
Georgetown Medical Clinic

Assignment of Benefits. I hereby assign to Georgetown Medical Clinic any insurance or other third-party benefits available for health care services provided to me. I understand Georgetown Medical Clinic has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Georgetown Medical Clinic**,** I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Georgetown Medical Clinic by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for Georgetown Medical Clinic, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Georgetown Medical Clinic or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Georgetown Medical Clinic or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X____Date_________________

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify) _________________________