

**FAMILY MEDICAL GROUP OF TEXARKANA
FINANCIAL POLICY**

The following is a statement of our **FINANCIAL POLICY** which we require that you read and sign prior to any treatment. You are required to provide us with your most current information and notify us immediately of any changes.

We accept cash, checks, credit cards, and money orders as form of payment.

There is a \$30 charge for every returned check.

Extended payment plans are available with prior approval.

There is a \$35 charge for each NO SHOW appointment that is not canceled prior to appointment time

MEDICARE/MEDICAID

As a participating provider for these programs, we accept assignment of benefits and will file all insurance claims for you. You may be responsible for full payment of any deductible and/or co-insurance at the time services are rendered.

PPO/HMO AND OTHER MANAGED CARE

Your insurance coverage is a contract between you and your insurance company. As a courtesy to you, we file your insurance claims. However, you are responsible for paying all co-payments, deductibles, coinsurance, and non covered services. We are not a party to the contract between the patient and their insurance company and have our own contractual obligations with each of the insurance companies we participate with. Even with assignment of benefits you are still ultimately responsible for all charges. If your carrier has not paid your account within 45 days it is your responsibility to contact them regarding your claim and notify our billing department of status.

WORKER'S COMPENSATION

Your services may be covered by insurance if your injury is reported at work and verified with your employer. Please be sure to inform the office personnel that the injury resulted during employment.

PERSONAL INJURY (accident)

We do **not** get involved with third party claims (e.g. motor vehicle accidents). We can bill your private health insurance for services provided and allow your claims to go through subrogation. If we are unable to obtain payment the charges for the services rendered will be your responsibility.

SELF PAY

Payment in full is due at the time of service. Payment plans may be arranged if necessary, although all account balances shall be paid in full within four months or less.

DELINQUENT ACCOUNTS

Accounts that are not paid in full or satisfactory arrangements not made within 90 days of service rendered are considered delinquent. Delinquent accounts may be referred to a collection agency, nationwide credit bureau or to our attorney for further action. All collection agency fees may be charged to the patient.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. Please sign below stating that you have read and understand our Financial Policy.

Patient or Responsible Party

Date