

Thank you for choosing us as your Primary Care Provider. We are committed to providing you with quality care. Please read this policy, ask us any questions you may have and sign in the space provided. A copy will be provided to you upon request.

1. INSURANCE - We participate in multiple insurance plans, including Medicare. If you are not insured with a plan we are contracted with, payment is expected at each visit. If you are insured by a plan we are contracted with, but, do not have an up to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. COPAYMENTS, COINSURANCE AND DEDUCTIBLES - All copayments, coinsurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. When we do not collect copayments, coinsurance and deductibles from patients at the time of service, it can be considered fraud. Please help us in upholding the law by paying your contracted fees at each visit. We accept cash, personal checks, debit and credit cards as form of payment. Any checks returned to us from the bank will be subject to a \$35.00 fee.

3. PROOF OF INSURANCE - All patients must complete our patient information forms before seeing a provider. We must obtain a copy of your current valid insurance card and a photo ID to provide proof of insurance and identity. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim. If your insurance plan changes, please notify us before your visit so that we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

4. CLAIMS SUBMISSION - We will submit your claims for the insurance companies that we are contracted with and assist you in any way we reasonably can to help get your claim paid. Your insurance may need you to supply certain information directly. It is your responsibility to comply with their request in a timely manner. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits are a contract between you and your insurance company.

5. NONPAYMENT - If your account is over 45 days past due after the insurance company has paid their portion and a statement has been sent out, partial payment will not be accepted unless otherwise negotiated. **Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice.** In the event of finding it necessary to turn your unpaid balance over to a collection agency, all collection fees and/or legal fees will be owed in addition to the remaining balance. If this occurs, you will be notified by regular or certified mail that you have 20 days to find alternative medical care. During that 20 day period, our providers will only be able to treat you on an emergency basis.

6. PRIVATE PAY – Payment is due at time of visit and will be collected before you see the doctor. Payment collected will be for the office visit fee, if any additional procedures, injections, etc are done during your visit then the additional fees will be collected at the end of your visit.

7. RECORDS, FORMS, APPOINTMENTS – An administrative fee of \$50.00 will be charged for the following: any forms (such as disability, FMLA, motor vehicle division, employment matters, assisted living, etc) that need to be reviewed and/or filled out by our physicians; copies of medical records released to insurance company, legal offices. A 24hour notice is required for cancellation of an appointment. If an appointment is not cancelled within this timeframe or if you miss/no show for your appointment you will be charged a fee of \$95.00.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. We reserve the rights to immediately discharge a patient from the practice who commits any of the following offenses, including but not limited to: abusive behavior/language; non-compliance with treatment plan/contract; Rx misuse; multiple missed office visits; or failure to pay. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy of REYNOSO MD Medical Center, LLC and agree to abide by its guidelines:

Patient Name (Print) _____

Signature of Patient or Responsible Party _____ Date _____