HealthCareClinics
the caring professionals

FINANCIAL POLICY

Thank-you for choosing HealthCareClinics for your medical care needs. We are committed to providing you with the very best care possible. The following is a statement of our financial policy that outlines patient and practice financial responsibilities. Please feel free to contact us at (214)826-2151 if you have any questions.

MEDICARE
HealthCareClinics accepts assignment for Medicare. We will file any secondary insurance claims. You may be asked to sign a waiver for tests/procedures that Medicare does not cover. You have the right to refuse these tests/procedures. You will be asked to sign a waiver stating that you have refused these tests/procedures.

ALL INSURANCE CARRIERS
Claims will be filed with your insurance company. You will be responsible at the time of service for all co-pays, co-insurance, deductibles and services not covered by your plan. Financial responsibility for services rendered rest with the patient regardless of any insurance coverage. Although we will do everything possible to facilitate reimbursement from your insurance company, we cannot guarantee payment of your claim. We file insurance as a courtesy. Insurance follow-up is the responsibility of the patient. If the claim becomes the patient's responsibility, the claim must be paid within 30 days.

HMO'S
The patient is responsible for obtaining and maintaining valid referrals for any and all covered services. The insurance department will assist in obtaining referrals for treatments. If the patient chooses to undergo any service without a valid referral, the patient is financially responsible for the full charges. Any and all co-pays are due at the time of service.

SELF PAY PATIENTS
Full payment is due at the time of service. We accept cash, checks, Visa, MasterCard and American Express.

CHANGE OF INSURANCE
IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH ANY INSURANCE CHANGES. Claims denied due to "untimely billing" will be the patient's responsibility, if we were not initially provided with the correct billing information, which resulted in late submission.

MEDICALLY NECESSARY SERVICES
The insurance company may deny some services as not medically necessary. The patient is responsible for all billable services.

STATEMENTS
Regardless of any claim pending, if there is an open balance a statement may be sent to you once a month. Any patient balances remaining after insurance payment must be fully paid within 30 days.

COLLECTIONS AND NSF CHECKS
Delinquent accounts will be forwarded to our collection agency. A collection fee of $25 will be added to the unpaid balance to recover our costs for collection. In the event litigation is necessary, you will be liable for court costs and attorney fees as well. A $30.00 fee will be charged for any NSF checks. Returned checks will be turned over to the Dallas County District Attorney's office.

CANCELLATION POLICY
Any appointment cancelled within 24 hours of the scheduled appointment time may be subject to a cancellation fee. If you need to cancel an appointment, please make sure that you have given us at least 24-48 hours notice.

MEDICAL RECORDS
Your medical records will be held in the strictest confidence. If you request a copy of your records to be sent to another physician or to yourself, a written authorization will be required. Our medical records department will notify you with the processing fees and any additional costs that may incur. Only the records requested will be forwarded. Should you bring in another physician's records to us, you may want to consider keeping a copy for yourself.

I hereby give my consent for HealthCareClinics to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. With this consent HealthCareClinics may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory and/or other pertinent results. HealthCareClinics may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. By signing below, I acknowledge that I have read and understand the information presented above and wish to receive diagnostic and treatment services from HealthCareClinics. I agree to be fully responsible for any and all charges for services rendered and not covered by my insurance plan.
A copy of this agreement may be used with the same effectiveness as an original.
PRINT NAME_____ SIGNATURE _____ DATE _____