Financial Policy & Agreement

Welcome to the Donna Medical Clinic, PA. In order for our medical staff to be able to deliver the quality of care that you are accustomed to, we have established our financial policies. The following is a list of guidelines that are necessary in order to provide high quality care and make your visit as pleasant as possible.

PLEASE READ ALL INFORMATION AND ACKNOWLEGE BY SIGNING BELOW

1. **We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance claims.**
2. **If you have a change of address, telephone numbers, or employer, please notify the receptionist upon signing in.**
3. **We will collect your deductible, co-payment, or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, visa, MasterCard and discover.**
4. **If we do not participate with your insurance company, you will be expected to make payment in full at the time services are rendered.**
5. **If your insurance denies our charges or does not pay us in a timely manner, or if your account becomes delinquent we reserve the right to refer your account to a collection agency and to be reported to one or more credit bureau(s).**
6. **MEDICARE PATIENTS: We are participating providers with Medicare and will bill Medicare for all of your covered charges. If you have supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your Medicare Deductible is met.**
7. **HMO-PPO PATIENTS: If we participate with your plan, we will bill your insurance for you. Your co-payment will be collected at the time of service-no exceptions. If your plan requires you to choose a primary care physician, it is your responsibility to make sure your insurance company has the physician and / or nurse practitioner you are seeing in our office as your PCP. If you plan requires you to have an authorization to see a specialist, you will need to obtain that from our office prior to seeing the specialist. No retroactive referrals will be given. If we do not participate with your plan, we will verify your out of network benefits, file your charges, and will expect payment of your portion of the charges at the time of service. If we are not your primary care physician, we will not be able to obtain an authorization for you to see a specialist or admit you to the hospital.**
8. **SELF-PAY PATIENTS: Patients with no insurance will be expected to pay at the time of service. If you will not be able to pay in full; you must contact our billing department prior to seeing the physician and or Mid-Level provider to payment arrangements.**

9. **NO SHOW OR MISSED APPOINTMENTS: When an appointment is scheduled with the physician or midlevel provider, time is specifically allocated for you. When an appointment is not canceled in advance, and the patient "no shows", another patient needing to be seen could have used that slot. We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel your appointment. If three appointments are missed, you will be dismissed from the practice for noncompliance.**
10. **Your insurance is a contract between you, your employer and the insurance company. We are not a part of that contract. It is very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policy holder. Reduction or rejection of your claim by your insurance does not relieve you of your financial obligation.**
11. **Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing office at 956-464-2402.**

I / We hereby agree to the following:

i. **GUARANTY OF PAYMENT: Medical care has been or will be provided to the patient whose name appears below. I / We, both jointly and individually, shall be fully responsible for payment for the patient's physician bill, based upon the physicians posted charges, which I/We agree are fair and reasonable. The physician my demand full payment of the patients bill at any time, but the physician is not required to do this. Even if the physician doesn't demand immediate payment, my / our obligation to make such payment remains the same.**

ii. **When the patient's insurance coverage is insufficient. If any insurance coverage which the patient may have, such as but not limited to (BCBS, AETNA, MEDICAID, HUMANA, CIGNA, WORKERS COMPENSATION) or any other coverage rejects the patients claim, or allows only part of the claim, I/We shall be responsible for immediate payment of the balance due, as determined by the physician.**

I have read and have a full understanding of the financial policy of Donna Medical Clinic, Donna Day & Night Clinic, Elsa Medical Clinic and Arango & Peña Family Clinic.

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Print Name   **Date of Birth**

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Signature   **Todays Date**

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