Round Rock | South Austin |Central Austin | Cedar Park |Georgetown | Waco| Killeen| Amarillo
Phone: (512) 244-4272 | Fax: (512) 244-2895 | www.austinpaindoctor.com

FINANCIAL POLICY

Patient's Name: Date of Birth:

Thank you for choosing **Advanced Pare Care, Advanced Rheumatology Care, and Round Rock Surgery Center** as your health care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our business office personnel. We ask that all patients read and sign our Financial Policy prior to seeing a medical care provider.

Patient's portion of payment, including co-pay, deductible, and/or balance on account is due at the time services are rendered unless prior arrangements have been made with the Billing Department.

We accept assignment with most major insurance companies and participating provider plans. However, you must understand that:

_____1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier. We verify your benefits as a courtesy and do not guarantee of coverage or payment.
_____2. All charges are your responsibility whether your insurance company pays or not.
_____3. Fees for services, along with unpaid deductibles and co-payments, are due at the time of treatment.
_____4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.
_____5. Returned checks will be subject to a $25.00 collection charge. If the check is not picked up within 10 days, the check may be turned over to law enforcement.
_____6. Completion of forms is subject to a $25.00 charge.
_____7. No show or cancellations without 24 hour notice are subject to a $25.00 charge.
_____8. Unpaid balances over 90 days may be subject to collections via small claims court, attorney, and/or collection agency with applicable collection fees. All collection fees are the responsibility of the patient.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Authorization to Release and Assign Insurance Benefits: I authorize release of **ANY** medical information, including substance abuse, mental health, and HIV/AIDS records, required to act on **ANY** medical insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to **Advanced Pare Care, Advanced Rheumatology Care, and Round Rock Surgery Center** the medical and/or surgical benefits I am entitled from my insurance company(s) and/or Medicare and Medicaid.

This authorization is in effect for all future claims, until I choose to revoke it in writing. I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment. I have had the opportunity to ask and have my questions answered to my satisfaction.

Patient Signature_____ Date_____

Printed Name _____

Relationship to patient if not patient _____Authorized Witness:_____

I have received or been offered and declined a copy of the Privacy Practices. I have had the opportunity to have any questions answered to my satisfaction regarding the privacy practices of the clinic.

Patient Signature _____ *Date*_____

Relationship to patient if not patient _____*Authorized Witness:* _____