COASTAL MEDICAL GROUP

150 EAST MEDICAL CENTER BLVD, SUITE D ♦ WEBSTER, TEXAS 77598
(281) 990-9979

INSURANCE PAYMENT POLICY

PAYMENTS FOR OFFICE VISITS:

Deductibles and co-payments will be collected at the time of the visit. All patients except those covered by a contracted plan such as HMO's, PPO's and Medicare are required to pay for office visits at the time of service. We will gladly and promptly refund the patient any overpayment that may result due to reimbursement by their insurance.

INSURANCE FAILURE TO PAY:

If your insurance has not notified you of payment to us within 30 days, the insured party is expected to contact the carrier and ask that the claim be paid. The insured assumes responsibility for the entire bill for claims that are not paid within 30 days. We are not responsible for collecting a disputed insurance amount.

PATIENTS DIRECT RESPONSIBILITY:

It is the patient's responsibility to notify the receptionist of any change of insurance and present the new card before services are rendered. Each account not paid in accordance with our payment requirements is subject to review for further collection measures. The patient will be liable for any incurred charges related to collection costs or legal fees.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to the practice named on this form.

This assignment will remain in affect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Current Primary/Secondary Insurance: _____

I CERTIFY THE ABOVE INFORMATION TO BE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

AGREEMENT

I HAVE REVIEWED A COPY OF THIS DOCUMENT TODAY AND AGREE TO ITS TERMS AND CONDITIONS FOR TREATMENT.

NAME _____ DOB _____

SIGNATURE _____ DATE _____