PAYMENTS

- Payments are expected at the time of service, which include co-payments, co-insurance, unmet deductible, and non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of you visit.
- Please bring your **photo ID** along with your **insurance card** to every office visit. We may have to reschedule your appointment if you do not have this information with you.
- We will accept cash, check, or credit card.
- **Returned checks** will incur a $30.00 service charge. You will be asked to bring cash to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services.
- **Stop payments** constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Hays County.

INSURANCE

- We are participating providers with **most commercial insurance plans**, and we also take **Medicare**. We will file all of these insurance claims. Please remember that insurance is a contract between the patient and the insurance company, and ultimately, the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.
- Please check with your insurance benefits department to ensure that our **Dr. Hijazi is in-network** for your particular policy. Many web sites have erroneous information and are not a guarantee of coverage. If not, you may be responsible for partial or full payment. Due to the many different insurance products out there, our staff can not guarantee your eligibility and coverage.

- You are responsible for obtaining a properly dated **referral** (if required) by your insurer and responsible for payment if your claim rejects for the lack of one.
- Not all insurance plans cover all services. In the event your insurance plan determines a **service to be "not covered"**, you will be responsible for the complete charge. Payment is due upon receipt of a statement form our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.
- Accounting Principals: Payment and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service.

- If you cannot make it to your appointment, please call the office to make us aware. **No show fees** ($25 for office visits and $50 for procedures) will be applied if you do not communicate your schedule changes with our staff.

FORM FEES

- Completing insurance forms, copying medical records, or any other requested forms requires office staff time and time away from patient care for our doctor. We require **pre-payment for completing forms**, copying medical records, notarizing, or any extra written communication by the doctor.
  - Form completion charge is determined by the complexity of the form, letter, or communication. Base form charges are $10+ per occurrence and applicable postage or notary fees. Postage is additional, and payment is required in advance.
  - Copying fees for Medical Records is $10 for the first 20 pages and $0.50 per page in excess of twenty. We will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for copying has been received and Release of Information has been signed.

I understand that I, personally, am financially responsible to LA Pain Doctor for charges not covered by the assignment of insurance benefits.

I hereby assign, transfer, and set over directly to LA Pain Doctor sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize LA Pain Doctor to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to LA Pain Doctor. I authorize LA Pain Doctor to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

I understand that LA Pain Doctor does not make payment arrangements or extend credit. All services are expected to be paid in full at the time of service.

I hereby authorize the and direct LA Pain Doctor to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

I have read and understand LA Pain Doctor's financial policy, and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of Patient Date

_____

Please Print the Name of the Patient