Office Policies

Walter D. Gracia, M.D., P.A.
1204 5th Avenue
Fort Worth, TX 76104
(817) 336-9450

Office hours: 9:00 a.m. - 5:00 p.m. (Monday - Thursday) & 8:00 a.m. - 12:00 noon (Friday)

Medications: Request for medication refills should be called in during normal business hours. Please do not request refills for medications after hours, they will not be responded to until the next business day. Keep track of your supply of medications and request refills before running out.

Medical and/or Billing Records: If a patient is requesting a copy of medical and/or billing records for personal use there will be a charge of $25.00 each for medical and/or billing records for the first twenty pages and $.50 per page for every copy thereafter. The physician may charge separate fees for medical and billing records requested.

We require 15 business days to process medical and/or billing records request. The physician may retain the requested information until payment is received.

Payment Policy: Payment is due when services are rendered.

Your insurance coverage is an agreement between you and your insurance company. It is your responsibility to obtain a current insurance referral for your appointment prior to the day of the appointment with us. If you do not have your referral upon arrival or on file we may need to reschedule your appointment. Payment of your account is your responsibility.

There is a fee of $30.00 for all returned checks.
We accept Visa, MasterCard, Cashier's Check or Cash.

Medications / Forms / Medical & Billing Records fee's are Not covered by your insurance.

Prescriptions renewals or replacement (without appointment) $25.00

Medical Records
Patient request for personal use ....$25.00 and up
Request to send to other physician ....No Charge
Billing Records ....$25.00 and up

Any forms to be filled out ....$25.00 and up
Multiple forms to be filled out ....$25.00 and up
Any forms to be filled out must be paid before and allow up to 5 business days to be completed.

General Consent of Medical Treatment:
I hereby authorize Walter D. Gracia, M.D. to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician all payments for medical services rendered me to dependents. I understand that I am responsible for any amounts not covered by insurance.

Patient Signature ____ Date _______________________