FINANCIAL POLICY

Healthcare Associates of Texas and its affiliates recognizes the need for a clear understanding between our patients and their healthcare providers regarding protected health information and the financial policies related to the provision of healthcare services. We dedicate ourselves to providing the best possible care for you, and the information below is provided to avoid misunderstandings concerning our financial policies and associated protected health information.

1. **PAYMENT: Payment is due at the time of your visit.** Payment includes any amounts due for copayments, coinsurance, unmet deductibles, non-covered charges and any balances from prior visits. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is due at the time of your visit. We require you to present your insurance ID card and driver's license at registration due to the increasing frequency of identity theft.

2. **INSURANCE:** We are participating, in-network providers with *most* insurance plans. **Please remember that your insurance is a contract between you and your insurance company. It is your responsibility to verify that we are a participating ("in-network") provider with your insurance. It is also your responsibility to understand what services your insurance coverage allows, and the financial responsibility you may have for such services.** If your insurance plan requires a referral authorization from your primary care provider, please present this before receiving services or upon registration. We will make our best estimate of the amount you owe for each visit prior to your arrival; however, any contractual amounts not paid by your insurance will be your responsibility. If your insurance company does not pay Provider within 60 days from receipt of a clean claim, the balance will become your responsibility. If we later receive payment from your insurer, we will refund any overpayment to you less any outstanding patient balances.

3. **SECONDARY INSURANCE:** The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider, if applicable. Patient agrees to provide such information. Patient agrees to notify **Provider** of any future additions, changes or deletions of primary or secondary insurance coverage.

4. **SELF-PAY:** If you do not have insurance coverage, please be prepared to pay in full for your services at each visit.

5. **RETURNED CHECKS:** Returned checks and stopped payments will incur a $30 service charge and are subject to collections activity. You will be required to bring cash, certified funds or money order to cover the amount of the payment plus the service charge before receiving services from our staff or physicians. Stopped payments constitute a breach of our payment policies and bad checks are subject to prosecution in Dallas County.

6. **ACCOUNTING PRINCIPLES:** Patient payments and credits for existing balances are applied to the guarantor's oldest charges first.

7. **FORMS FEE:** Completing forms such as long-term care, life insurance, and Family Medical Leave Act (FMLA) ("Administrative Forms") requires considerable office staff time and time away from patient care for our doctors. Provider charges a processing fee of $25 per form and a completion fee of $5 per page (maximum $50 per form) for Administrative Forms. Payment is due at the time of the request. Provider will not charge an additional fee for forms associated with a special exam such as school, camp, sports participation and disability determination.

8. **MEDICAL RECORDS COPYING:** Provider will not charge for transferring medical records directly to another physician's office. Provider charges $25 for the first twenty (20) pages and $0.50 per page more than twenty for requests to copy and provide medical records for yourself in paper form. Provider will have 15 business days in which to copy records before making them available for the patient to pick up. These 15 business days will commence after payment for copying has been received and after the patient has signed an Authorization of

Records Release form. For an electronic copy of your medial record, Provider will charge $25.00 for the first 500 pages.

9. **BILLING OFFICE:** If you have questions regarding your billing statements, our accounts receivable staff is available to assist you. **Call 972-594-1524 with any billing concerns.**

10. **CANCELLATIONS OR MISSED APPOINTMENTS:** If you do not cancel your appointment at least 24 hours in advance, or if you are a "no-show," we may assess you a $50 missed appointment fee. Multiple appointment cancellations or no-shows may lead to the dismissal of the patient from our practice.

11. **RESPONSIBILITY FOR PAYMENT:** I understand that I am financially responsible to Provider for charges not covered by the assignment of insurance benefits. **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

12. **ASSIGNMENT OF INSURANCE BENEFITS:** I authorize **Provider** to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. **Provider** will collect payment for supplies and services provided. I understand that I am financially responsible to the Provider(s) for the charges not paid or payable.

13. **RELEASE OF INFORMATION:** I authorize and direct **Provider** to release to government agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claims and payment.

14. **COLLECTION FEES:** I understand if my account reaches collection status, any additional fees incurred due to this, will be added to my outstanding balance, including but not limited to late fees, collections agency fees, court costs, interest, and fines. I understand that these additional fees will be my responsibility to pay in full.

15. **CHILDREN OF SEPARATED OR DIVORCED PARENTS:** By signing below, the parent or guardian who signs a minor child into our office on the initial visit accepts responsibility for payment for that visit. **Provider** is not responsible for sending bills or records to the other parent/guardian. We will communicate about treatment and payment with the parent or guardian who signs in the patient. Parents and/or guardians are responsible for communicating with each other about treatment and payment issues.

16. **CONSENT TO TREATMENT:** I consent to treatment as deemed necessary by HCAT providers and employees.

I have read and understand the Provider's financial policy, and I agree to be bound by its terms.

I also understand and agree that the Provider may amend these terms from time to time.

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Signature of Patient (or Guarantor, if applicable) Date

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Please print the name of the patient