Texas Kidney
INSTITUTE

Financial Policy and Agreement

In order for our medical staff to be able to deliver the quality of care that you are accustomed to, we have established our financial policies. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible.

PLEASE READ ALL THE INFORMATION AND ACKNOWLEGDE BY SIGNING BELOW

1. Please present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance. If you have a change of address, telephone number, or employer, please notify the office
2. We will *collect your co-pay, deductible, or charge for non-covered services at the time of your visit.* If you have balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, check, Visa and MC
3. If we do not participate with your insurance company, you will be expected to make payment in full at the time the service is rendered.
4. If your insurance denies our charges or does not pay us in a timely manner, or if your account becomes delinquent, we reserve the right to refer your account to a collection agency and to be reported to one or more credit bureau(s). If your account is referred to a collection agency, you will be billed the amount you owe plus 30%
5. MEDICARE PATIENTS: We are participating provider with Medicare and will bill Medicare for all your charges. If you have supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due. If you do not have supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service
6. HMO-PPO PATEINTS: If we participate with your plan, we will bill your insurance for you. Your co-payment will be collected at the time of service – no exceptions. If your plan requires you to have an authorization to see a specialist, you will need to obtain that prior to seeing the specialist. No retroactive referrals will be given. If we do participate with your plan, we will verify your out-of-network benefits, file your charges, and will expect payment of your portion of the charges at the time of service
7. SELF-PAY PATIENTS: Patients with no insurance are expected to pay at the time of service. If you will not be able to pay in full; you must contact our practice administrator prior to seeing the physician to make payment arrangements.
8. No Show or missed appointments: We understand that there may be times when you an unable to keep your appointment, but we ask the courtesy of a phone call to cancel or re-schedule your appointment. If two(2) appointments are missed without cancellation, you will be charged a $25.00 fee.
9. Your insurance is a contract between you, your employer and the insurance company. WE ARE NOT A PARTY TO THAT CONTRACT. It is very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policy holder. Reduction or rejection by your insurance does not relieve you of your financial obligations. You will be responsible for the balance due.
10. Non-covered Medicare/Medicaid Services and HMO/PPO/Private Insurance: Insurance have certain outpatient services/procedures that are excluded from coverage, included but not limited to those routine diagnostic workups, labs or routine examinations. If your insurance does not pay/cover all the charges, the charges incurred during treatment will be your financial obligation.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our policy and this agreement, please contact our practice administrator at (214) 396 4950.

I have read and have a full understanding and agree to the terms of the Financial Policy and Agreement of Texas Kidney Institute (Straightline Medical Consultants)

Name of Patient: _____ Date: _____

www.texaskidneyinstitute.com
Tel: 214 396 4950 Fax: 214 613 2925

Signature of Patient: _____

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