BRAZOS
INTEGRATIVE MEDICINE

Financial Policy
Patient Financial Agreement

Brazos Integrative Medicine is committed to serving our patients with professionalism and caring and from our patients we expect the same commitment. This includes being on time for your appointment and calling to cancel an appointment if you can't make it. It also includes financial responsibility, like presenting your identification and insurance cards at every appointment and making your copay and deductible payments at the time of your office visit with cash, check or credit card.

Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit. As a courtesy, Brazos Integrative Medicine will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you.

For services outside of our clinic, like radiology, laboratory, surgery centers, physical therapy, hospitals and rehabilitation centers, it is your responsibility to know which facility you are required to use. If you aren't sure, please talk to your insurance member services or one of our staff before scheduling.

I understand that my signature requests payment be made to pay my claim. My signature also authorizes the release of medical information necessary to pay my claim. My signature also authorizes the release of benefits payable and medical information necessary to pay any secondary insurance payer.

I have read and I understand Brazos Integrative Medicine's financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Date**

Patient Financial Responsibility Contract

Please read, initial each blank and sign where indicated – this document describes your financial responsibilities.

This is a legally binding contract between Brazos Integrative Medicine and you. The words, *I, me, my, you and your* all refer to the patient.

_____ (initial) I agree to be financially responsible for payment of Brazos Integrative Medicine's services. Cash, check or credit cards are acceptable forms of payment for these services.

_____ (initial) Current insurance cards must be presented at every office visit. Brazos Integrative Medicine is not responsible for filing your insurance claim, but as a courtesy we will do so. I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt of a statement.

_____ (initial) I agree to give Brazos Integrative Medicine my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment. I agree to pay Brazos Integrative Medicine the balance on my account after my insurance claim has been processed.

_____ (initial) I agree that if my insurance benefit requires me to provide a referral and if the referral is not in place before my appointment, that I will pay in advance an estimate of charges for my office visit or reschedule my appointment.

_____ (initial) I understand that I will be responsible for any missed appointments or any canceled appointments in which a 24 hour notice was not given. There will be a fee of $50.00 for any missed office visits.

_____ (initial) I understand there will be a $35.00 fee for all returned Checks

_____ (initial) I understand that all services provided to me by Brazos Integrative Medicine are considered medically necessary, if I fail to have a procedure performed or do not comply with my provider's instructions it may be against medical advice and may void my insurance benefits. Should this occur, I agree to pay the balance remaining on my account after my insurance has been processed.

_____ (initial) I understand that my insurance may or may not agree to the usual, customary or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been approved of in advance. I agree to pay the balance remaining on my account after insurance has been processed.

_____ (initial) If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

_____ (initial) Brazos Integrative Medicine has a contract with my insurance company. Brazos Integrative Medicine will receive payments from my insurance company for ***covered*** services provided by my insurance benefits. I agree to pay co-payments and deductibles at the time of service. If co-payments and deductibles are not made at the time of service, I understand that my appointment may be no-showed.

_____ (initial) I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must give Brazos Integrative Medicine my current address and other contact information. I understand that if I fail to pay the balance on my account this may result in Brazos Integrative Medicine pursuing any collection means possible.

I have read and I understand Brazos Integrative Medicine's financial policies and I accept responsibility for the payment of any fees associated with my care.

Patient Signature **Date**

Witness Signature **Date**

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to Brazos Integrative Medicine. This is a **DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS**. This authorization will remain in effect until canceled by me in writing. A copy of this authorization is as valid as the original document.

I authorize the release of any medical information necessary to in order to obtain payment and I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured I am responsible for the charges of all services provided to me. I authorize Brazos Integrative Medicine to deposit checks received on my account when made out in my name.

I have read and I understand Brazos Integrative Medicine's financial policies and I accept responsibility for the payment of any fees associated with my care.

Patient Signature **Date**

Witness Signature **Date**