

## Financial Policy

Thank you for choosing Bee Caves Medical as your healthcare provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy, which we ask you to read, sign and return to us prior to your treatment.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
- All applicable co-pays, personal balances, both current and prior, are due at the time of service.
- We accept cash, check or MasterCard/VISA/Discover/American Express credit cards.

### *Regarding Insurance*

Bee Caves Medical participates in only a few insurance plans at the current time. As participation in additional plans becomes available, we will make a list of those insurance groups available both at our office and on our website. For some insurances, we accept assignment of benefits, but in all cases require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies.

### *Usual and Customary Rates*

We were committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region and specialty. If your insurance company uses a different fee schedule, you will be responsible for any balance remaining.

### *Past Due Accounts*

Overdue accounts will be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account.

### *Co-Pay Balances*

Payment for co-pays is expected at time of service. Legal fees that we pay to secure past due balances will be added to your account. This fee is not covered by insurance so it will be your personal responsibility.

### *Returned Checks*

For checks returned to us as unpaid by your bank, we will charge a returned check fee of \$25.00.

Please contact our Billing Office if you have questions or concerns at 512.327.4243.

I have read the Financial Policy. I understand and agree to the Financial Policy.

You have authorization to charge my credit card for any current or past due personal balance(s) upon receiving my verbal of written permission.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_