Conroe Family Medicine

Office and Financial Policies

Welcome and thank you for choosing Conroe Family Medicine for your medical care. We are committed to providing you with the highest quality medical care in an efficient, timely and cost-effective manner. We hope that by providing you with our policies in advance we can prevent any misunderstanding or frustration at the time of your visit.

Initials:_____ **Insurance: The patient is responsible for knowing their insurance benefits and if you have a deductible or copayment.** If you have an **HMO** policy you must change your PCP to one of our doctors in the facility. If it is not changed prior to the appointment you may be asked to reschedule or will be responsible for all services done that day. We will gladly file your insurance claim on your behalf. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefits. You are responsible for the timely payment on your account.

Initials: _____ **Cancellations/No Show**: Please call our office 24 hours in advance if you are unable to keep a scheduled appointment. If you do not call in the allowed time frame we may charge a fee of $25 that is due before your next visit.

Initials:_____ **Referrals:** Patients with an **HMO** policy need referrals to see any specialist. It is the patients' responsibility to inform the referral coordinator before you have scheduled an appointment with a specialist. We are unable to do same day referrals and require **3 business** days to get an authorization back from the insurance company.

Initials:_____ **Check-in:** Please arrive about 15 minutes before your scheduled appointment time, so that all paperwork may be completed before you see the physician. Please also bring your insurance card with you to **every** appointment. Without the insurance card we will be unable to file your insurance and you will be responsible for the charges for the day. On follow-up appointments you will be asked to verify demographic and insurance information so our records remain up to date. Your copay is due at time of check in.

Initials:_____ **Check-out:** Please be prepared to pay for the current visit as well as any past balances on your account. Deductibles, percentages or fees for non-covered services will be required at the time of service. For your convenience we take cash, check and credit cards.

Initials:_____ **Late arrivals:** We do our best to keep to the schedule. When a patient arrives late it is impossible to stay on schedule. If you arrive more than 15 minutes late you may be asked to reschedule your appointment so that other patients are not inconvenienced.

Initials:_____ **Dishonored checks:** A $30 service fee will be assessed on all dishonored checks. The full amount of the check written plus $30 must be paid by cash or credit card. If payment is not received within 10-15 business days your information will be filed with the Montgomery County Hot check Division. We will be unable to see you until payment is made in full. If you have 2 occurrences we will no longer be able to accept a check from you.

Initials:_____ **Collections:** You will be receiving at least 3 statements from our office for balances owed. Please ensure to make payment arrangements, if necessary, to keep your account current. If your address changes it is your responsibility to inform our office to update our records, otherwise, your account will be turned over to collections when it is returned as a bad address. When your account is already in collections, you **may not** be seen until the account is paid in full at the collection agency.

Initials:_____ **Prescriptions:** It is the patients responsibility to call the pharmacy 5 days prior to running out of medication. **Refills may take between 2 - 4 business days to be refilled.**

Initials:_____ **Prior Authorization:** A $25 fee will be due for any prior authorization that is needed on any medications. This only applies to specific medications when insurance companies are requesting additional information.

Initials: _____ **Disability/FMLA papers:** A $25 fee will be charged for forms completed by provider.

I have read understand and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing and pre-certification by signing this statement.

Patient name:_____ DOB: _____

Signature:_____ Date:_____