Print Name _____

Heart Center of North Texas, P.A.
Financial Policy

We are happy that you have chosen us as one of your healthcare providers. As a partner in our relationship, it is important that you understand and agree on our financial policy.

We must first understand that our relationship is with you as our patient. Your insurance is a contract between you and your insurance company and possibly your employer. You are responsible to understand your policy and it's terms including referrals and pre-certifications necessary prior to your visit.

It is your responsibility to provide us with your most current billing information to include: Insurance I.D. Card, address, all available phone numbers, and contact information. These must be updated at each visit.

Before we can provide services, we must first verify that we are participating providers with your insurance company. If we are participating providers with your insurance, it is possible that not all services provided are covered by your insurance, if so; you are responsible for payment of these services.

If we are not providers for your insurance company, Full Payment is due prior to service. We will file your claim provided we are paid in full at time of service.

All Co-Pays and Deductibles are due at time of service. These are **ESTIMATES** provided by your insurance company. You are responsible to pay any differences in the **estimate** and what is **actually paid** by your insurance as these numbers are often different.

We will send you a statement on a monthly basis of balances due. These must be paid in full within 30 days. **If you have an overdue balance we will not schedule a new appointment until all balances are paid in full.**

Balances may be paid by cash, local check and credit cards (Visa, Master Card, American Express and Discover). Returned checks will be charged a $30.00 return check fee.

If your overdue account is sent to a collection agency, full payment of prior charges will be required in order for you to make an appointment.

Full payment is due at time of service. I have read and understand this Financial Policy.

_____ _____

Signature of Responsible Party **Date**

Patient Name:_____ Patient Date of Birth:_____