Downtown Doctor Financial Policy

Thank you for choosing Downtown Doctor for your health care needs. We are committed to providing you with quality care. The purpose of this financial policy is to better inform and advise you of your responsibility for services rendered.

- **INSURANCE** We participate in most insurance plans. If you are insured by a company we are not contracted with or in network with, payment in full is expected at the time of service. Knowing your insurance information is your responsibility as it is a contract between you and your company. If you have any questions please contact them with any questions about coverage.
- **CO-PAYS, COINSURANCE AND DEDUCTIBLES** All co-payments, coinsurance and deductibles are to be paid at the time of service. This is part of your contract with your insurance.
- **AFTER HOURS' FEE** If you are seen after 5pm, before 8am, or on a weekend you may be responsible for a $25 fee for this convenience.
- **NON-COVERED SERVICES** Please be aware that that at times some or all of services you may receive here may be non-covered or not considered to be reasonable or necessary by your insurer. You will be responsible for these services in full.
- **PROOF OF IDENTITY AND INSURANCE** All patients must provide proof of identification and a valid insurance card to us prior to being seen by the physician. If you are unable to provide these items you will need to be rescheduled.
- **CLAIMS SUBMISSION** We submit your claim and assist you in every way we reasonably can to help you get your claims paid. Your insurance company may need you to supply additional documents or information to them directly in order to have your claims paid. It is your responsibility to comply with their request. You are responsible for any remaining balance after your insurance has processed your claim. The benefits provided are part of the contract between you and your insurance company and we care not party to this contract.
- **CHANGES TO YOUR INFORMATION** If your address, phone or insurance changes we ask that you notify prior to next appointment so that we may make the appropriate changes to maximize your benefits.
- **NONPAYMENT** Please be aware that if your balance remains unpaid for more than 90 days, we will refer your account to a collections agency and you will not be eligible to be seen here at this practice until the balance is cleared. If you receive a bad debt write off, we will no longer be able to treat you and you will be discharged with a written notice sent by certified mail to you.
- **RETURNED CHECKS** Our office charges a $38 fee for returned checks.
- **BILLING INFORMATION** If you have any questions about your account, please contact our billing company at 512-275-6426. Our billing address is 1611 W. 5th Street, Suite 180, Austin, Texas 78703.

I have read and understand the payment policy and agree to abide by its guideline.

Patient Name: _____ Acct# _____

Signature:____Date_____________________