

Lake Lewisville Pediatrics  
2141 Edmonds Lane  
Lewisville, Tx 75067  
972-315-8500

### FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered a part of your treatment. The following is a statement of our financial policy which we request you to read, agree to and sign prior to any treatment.

#### PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE

We accept cash, checks, Visa and MasterCard.

#### REGARDING INSURANCE

Our office is pleased to assist you in filing claims with your insurance company for reimbursement of these expenses. We will wait 45 days for your insurance company to pay your claim and if they do not we will give you 30 days to pay the balance.

1. The patient is responsible to pay any deductible and copayments at the time services are rendered.
2. Any portion of a billed amount that is labeled "disallowed" or "not covered" will become the patient's responsibility.
3. Our office NEVER guarantees that your insurance will pay. We will make every attempt at verifying your policy benefits. However, if for some reason your insurance claim is denied, you are responsible for the amount due on your account immediately.
4. For your best interest, we recommend that you also contact your insurance company to verify coverage on your policy.
5. We will not file insurance for patients that live out of state, or do not reside in our service area.

#### USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary.

#### NSF CHECKS

All returned checks will be assessed a \$30 fee. All returned checks not paid in 10 days will be filed with the proper authorities.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to the provisions of this financial policy.

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Signature of patient or person responsible for the bill

Date

#### NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants may be reported for investigation at the following address:

Texas State Board of Medical Examiners  
1812 Centre Creek Drive, Suite 300  
P.O. Box 149134  
Austin, Tx 78714-9314

Assistance in filing a complaint is available by calling the following number: 1-800-201-9353