LAKE
LEWISVILLE PEDIATRICS

Lake Lewisville Pediatrics
2141 Edmonds Lane
Lewisville, TX. 75067

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.

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes release of any information relating to claims for benefits submitted on behalf of myself and/or dependents. I further express and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. Any copy of this document is as valid as the original.

I, _____,hereby authorize _____

(PRINT NAME OF INSURED) **(PRINT NAME OF INSURANCE COMPANY)**

to pay and hereby assign directly to LAKE LEWISVILLE PEDIATRICS all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to LAKE LEWISVILLE PEDIATRICS will be credited to my account, in accordance with above said assignment.

x_____ _____

(AUTHORIZING SIGNATURE/PARENT OR GUARDIAN) **(DATE)**

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 provide 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 $30.00 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.

_____

Signature of patient or person responsible for 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 filling a complaint is available by calling the following number: 1-800-201-9353