NW CYPRESS
PEDIATRICS AND FAMILY MEDICINE

11240 FM 1960 West, Ste 210
Houston TX 77065
Phone: 281-469-7400
Toll Free: 1-877-563-0817
Fax: 281-469-7403

PAYMENT POLICY

Thank you for choosing NW Cypress Pediatrics and Family Medicine, PLLC. We are committed to providing you with quality and affordable health care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy.

1. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
2. Non-covered services. Please be aware that some – and perhaps all of the services you receive may be non-covered or not considered reasonable and necessary by Medicaid or other insurers. You must pay for these services in full at the time of visit.
3. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance at each visit. Often this verification requires us to share the reason for your visit with your managed care plan.
4. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.
5. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

UNACCOMPANIED MINORS
Minor must have an authorization for medical treatment signed by his/her parent/guardian and is responsible for providing current insurance information for self. Please note that co-payments and/or deductibles are expected at the time of service.

REGARDING DIVORCE:
We do not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse.

REGARDING INSURANCE
Indemnity/Fee for Service: We require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your insurance company. Should your insurance company require a more detailed description of services, please have them request it in writing. Insurance is a contract between you and your company. We are not a party to your contract. We will not become involved in disputes between you and your insurance. You are responsible for timely payment of your account.

_____INITIAL

CONTRACTED MANAGED CARE PLANS (HMO, PPO, POS, EPO)
Each time you make an appointment with us, it is your responsibility to make sure the patient is currently under contract with your managed care plan.

Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your managed care plan.

I have read and understand that I am personally responsible for payment on this account.

Assignment: I hereby authorize payment directly to NW Cypress Pediatrics and Family Medicine, PLLC. Any changes in this authorization must be received in writing within 30 days of the effective date.

I understand that this practice has a no show appointment fee of $25 dollars. I am responsible for paying the fee if I do not cancel an appointment with 24 hours notice.

In the event my insurance company deems a service to be “non-covered” I understand that I am personally responsible for payment.

I agree to the release of any and all medical information, including HIV test results, and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. Any changes to this authorization must be received in writing within thirty days of effective date.

Guarantor Signature: _____ **Date:** ____/____/_____

Print Name: _____**Guarantor Date of Birth:** ____/____/_____

Relationship to Patient: _____

PATIENT(S) NAME: _____ **Date of Birth:** ____/_____/_____