Plano Wellness Medical, PLLC
Plano Wellness, PLLC

Patient Financial Agreement

The following information is provided to all our patients, new and established, to inform patients of our office financial policies and of patient financial responsibility requirements. Please ask a team member if you have any questions regarding these policies.

- We are happy to bill your insurance as a courtesy; however, all charges, regardless of insurance coverage are your responsibility as our patient. We do expect payment for your portion at the time of service. (co-pays, co-insurance, deductibles). We ask that if your insurance has not paid within 45 days that you follow up with them.
- If you are seen for both an annual preventative exam and a separate problem/illness is identified and also addressed, proper coding will be used. This may result in a charge for both services. Additionally, some medically indicated lab tests may not be covered as a preventative screen by your policy. Your individual contract with your insurance carrier will determine how your insurance will pay. We make every effort to bill each visit with the proper diagnosis and procedure codes according to national coding guidelines. Please understand that we cannot make exceptions to our coding practices due to federal and state legal compliance concerns, and we are unable to bill for services other than those documented in your medical record.
- Injections and some medical supplies must be paid for in advance at the time of service. Specialized products or services must be preauthorized with insurance prior to service; otherwise, these services will need to be paid in full by the patient at the time of service.
- For surgical care, we will pre-certify your insurance and obtain the estimated patient responsibility for the procedure. This amount is due prior to the scheduled date of surgery. If the procedure results in additional charges, these fees will be billed to you. We would ask that you pay the balance within 30 days following your surgery.
- We routinely send our laboratory testing to third-party laboratory companies. The aforementioned providers may or may not participate with your health plan. You may request that we refer your testing to another location. This request will need to be done with each visit.
- It is necessary to strictly enforce the policy of financial obligation. All co-pays, patient self-payment, and estimated patient financial responsibility may be paid by cash, check, or VISA, MasterCard.
- **There will be a charge for no show of $50 for missing a scheduled appointment without a cancellation notice. A charge of $25 will be applied to a cancellation notice of less than 24 hours (business hours) for office visits and $100 for surgical procedures. Payment of this fee is the responsibility of the patient and cannot be filed with insurance companies.**
- The charge for paperwork (for example Family Medical Leave Act (FMLA) & Short Term Disability applications) is $25 for a long form and $10 for short forms. This is payable in full at the time the form is left for completion.

Assignment of Benefits: (ALLOWS US TO FILE YOUR CHARGES WITH YOUR INSURANCE):
We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance at the time of service. If this account is assigned to an attorney for collection and or suit, the prevailing party shall be entitled to reasonable attorney's fees for costs of collection.
I understand that I am responsible for providing all insurance information at the time of registration to allow for verification of benefits, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to **Plano Wellness Medical, PLLC or Plano Wellness, PLLC**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that in the event my health plan determines a service to be "non-covered", I will be responsible for all non-covered and allowable charges. I hereby authorize said assignee to release all information necessary to secure payment.

I have read and understand the above information and agree to comply with these financial policies.

Signature: _____ Date: _____

Print Name: _____