

## **Authorization and Assignments**

Thank you for choosing Woodlands Functional Family Medicine. We realize you have a choice in selecting healthcare and we are honored you have chosen us. Our staff is committed to providing our patients with the highest quality of care possible. In doing so, we would like to provide you with information regarding our office policies. Please feel free to contact our office anytime Monday – Friday during routine business hours if you have questions, concerns, or suggestions.

### **Office Policy**

We participate with many health plans and as a courtesy to our patients, we file claims with these companies. It is ultimately your responsibility for the full and timely payment of your account.

### **Check In**

Please be prepared to submit the following documents when checking in for each visit. These documents will be scanned and saved as part of your patient record.

- Current Insurance Card
- Current Photo Identification
- Update to contact information such as home address, phone numbers, contact information, email address, employer information, etc.

### **Verification of Benefits**

We will attempt to verify coverage and benefits prior to your visit. If we are unable to obtain a verification of coverage, you may be asked to pay in full or reschedule your visit for a time the verification can be obtained. This verification will be used to estimate your financial responsibility; however, this verification is not a guarantee by your health plan to pay for services received.

### **Payment of Patient Responsibility**

Payment of your estimated patient responsibility is expected at the time services are rendered. This payment will include known deductibles, copays, and coinsurance amounts applicable for each visit and or procedure. While we may estimate your financial responsibility, it is your insurance company that makes the final determination regarding eligibility and benefits. For your convenience we accept cash, checks, most major credit cards and debit cards.

### **NSF Checks/Denied Credit Card Payments**

You will be charged a \$25.00 fee should a payment be returned for insufficient funds. This fee applies to payments made at our front desk, mailed in to the Business Office, electronically via the internet, or payments by phone.

### **Past Due Amounts**

In the event your account becomes past due, and all efforts to collect payment have failed, your account may be referred to a collection agency.

### **Additional Services Identified During Treatment**

Please be aware additional charges may be incurred if during the course of a physical exam a physician addresses, diagnoses, or treats problem-focused health concerns unknown at time of check in.

### **Non Covered Services**

Please be aware certain office procedures or services may not be covered, or may be considered “not medically necessary”, “experimental”, “cosmetic”, or simply “non-covered” by your health plan. You are responsible for payment of these services. In the event your care exceeds a plan limitation, you will be responsible for the balance. It is your responsibility to know the benefits and limitations of your current health care coverage. This clinic will provide medically necessary care based on patient’s needs, not a patient’s insurance coverage. This clinic is not responsible for knowing your plan’s specific benefit and coverage limitations.

### **Third Parties Insurance**

We do not file insurance claims to non-contracted third parties involving automobile accidents, accidental injury, property insurance, etc. You will need to pay in full at the Time of Service and file the claim with your insurance company. An itemized statement may be obtained by calling our business office. This statement will assist you with reimbursement. It is your responsibility to file claims in these instances.

### **Appointment Scheduling**

Please be advised, as a courtesy, an automated service will call the primary phone number listed on file to remind you of your appointment date and time. You must notify the office within 24 hours of your scheduled appointment if you are unable to keep your appointment. Failure to notify the office within 24 hours may result in a \$25.00 assessment to your account. Repeated failure to call and cancel your scheduled appointment without the proper 24 hour notice may result in your dismissal as a patient.

### **Forms/Medical Letters**

We are happy to assist you by completing forms and generating medical letters for you upon your request. The fee for this service varies depending on the form or letter, but most do not exceed \$25.00 per form. Payment is collected when you pick up the documents. Please allow 10 business days.

### **Medical Records**

Requests for your medical records must be in writing via a special release form. Release of records is managed via an outside vendor. The cost is \$25.00 for the 1<sup>st</sup> 20 pages and \$.50 for each additional page. You will pay the outside vendor for these copies.

### **Office Hours**

Our office staff is available by telephone 9:00am to 5:00pm Monday through Friday. Because our providers and nurses are often tending to patients, it is typically necessary for you to leave a message. So we may assist you in a timely manner, please leave pertinent information to include the reason for your call and best number to call. We have an answering service to take your calls before and after our scheduled office hours.

- Emergency Needs – always call 911
- Prescription Refills – call during regular office hours and if leaving a message, provide your name, the medication, your pharmacy name, location, and phone number. Refills of controlled substances and/or narcotics MUST be filled by speaking with a medical staff member.

**Authorization to Release Information**

I hereby authorize WOODLANDS FUNCTIONAL FAMILY MEDICINE to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of an examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked in writing.

**Assignment of Benefits**

I hereby assign all medical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct insurance carrier(s), include Medicare, Medicaid, private insurance and any other health/medical plan, to issue payment check(s) directly to WOODLANDS FUNCTIONAL FAMILY MEDICINE for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

**Financial Responsibility**

I acknowledge I have requested medical services from WOODLANDS FUNCTIONAL FAMILY MEDICINE on behalf of myself and/or my dependents, and understand that by making this request I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I agree to pay WOODLANDS FUNCTIONAL FAMILY MEDICINE for all services and products administered. I understand and acknowledge that any monies collected prior to the date services are rendered or products are administered will be applied as a deposit towards total charges assessed for the services rendered. The deposit shall not be considered payment in full. If I participate in a managed care plan, such as an HMO or PPO, I promise to pay for any services or products administered that are not covered under the plan as a result of inaccurate, incomplete or untimely patient information provided by me to the clinic and for any out-of-network charges.

I further understand that fees are due and payable on the date the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

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My signature certifies I have read and understand the above content of this document.

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Print Patient Name

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Patient Date of Birth

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Patient/Guardian Signature

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Date