

Dallas Internal Medicine and Geriatric Specialists, PLLC

601 Clara Barton Blvd, Suite 145

Garland, TX 75042

PH: 972-560-9400

Financial Policies

Thank you for choosing Dallas Internal Medicine and Geriatric Specialists. We are committed to providing quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibilities for services rendered, we have developed this financial policy. Our billing office is located in Dallas and can be reached at 972.792.5700 if you need assistance.

INSURANCE:

We participate in most insurance plans, including Medicare. Please bring your up-to-date insurance card with you to each visit. It is your responsibility to make sure that our providers are on your specific plan and in-network for you. If you are insured by a plan we accept, but do not have an up-to-date insurance card, payment in full is required until we can verify your insurance coverage. If you are not insured by a plan we do business with, payment is required in full at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

PROOF OF INSURANCE:

We must obtain a copy of your driver's license and a current valid insurance card to provide proof of insurance. If your health insurance changes, please notify us before your next visit so we can make the appropriate changes to help you maximize your benefits. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim.

CO-PAYMENTS, CO-INSURANCE & DEDUCTIBLES:

All co-payments, co-insurance 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, co-insurance and deductibles from patients can be considered fraud. Please be aware that your insurance company may require a second co-pay if you address other problems during a physical exam or at the same time you have a procedure scheduled. We accept cash, check, Visa, MasterCard and Discover.

CLAIM 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 to them. 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. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies a claim for any reason, our office cannot be responsible for that bill. It is your responsibility as the patient to pay the denied amounts in full. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. It is your responsibility to know if our providers are in-network for your insurance plan and what your specific insurance plan's benefits are.

NON-COVERED SERVICES:

Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurance plans. Please be aware that your insurance company may require a second co-pay if you address other problems during a physical exam or at the same time you have a procedure scheduled. Concerns dealing with mental health issues such as anxiety, depression, attention deficit disorder, and stress-related problems, etc. might not be covered by your insurance. If you are seeing our doctor for any of these problems, you may want to contact your insurance company to see if they are covered if seen by any physician other than an approved mental health provider. As with all non-covered services, you will be expected to pay in full whatever the insurance companies do not reimburse.

NONPAYMENT:

If your account is over 90 days past due, you will receive a letter stating that the balance should be paid in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. Should this occur, you will be notified by certified mail and will have 30 days to find a new physician.

MISSED APPOINTMENTS:

If you cannot keep your appointment, you will need to reschedule your appointment 24 hours in advance. This will allow us to schedule another patient in that time slot. If any appointment is no-showed, cancelled with less than 24 hours notice or rescheduled due to late arrival, a \$35.00 charge may be billed to your account. This charge is not payable by your insurance company. If multiple appointments are missed and we identify a problem with you keeping appointments, we will not be able to provide care for you at this office.

FORMS:

There is a \$25 charge for the completion of FMLA, disability and other forms. Since insurance companies do not cover this service, this charge is your responsibility. Payment is due at the time the forms or requests are dropped off at the clinic.

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Sex: M or F

Address: _____ City: _____ State: _____ Zip Code: _____

Home phone #: _____ Mobile #: _____ Work #: _____

Email: _____

Email address is required for patient portal access.

Marital Status: _____ SS#: _____

Referred by: _____ Relationship: _____

Primary Insurance: _____ Policy Holder Name: _____

ID# _____ Group # _____ Policy Holder DOB: _____

Secondary Insurance: _____ Policy Holder Name: _____

ID#: _____ Group#: _____ Policy Holder DOB: _____

Preferred Pharmacy: _____ City: _____ Phone #: _____

Pharmacy Intersection: _____

Patient Preference Regarding Communication of Health Information

Who To Contact: I hereby give my permission to Dallas Internal Medicine and Geriatric Specialists to disclose and discuss information related to my medical condition(s) to/with the following persons.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

_____ I do not wish to give consent for any persons to have access to any information regarding my medical condition(s).

Emergency Contact: _____ Phone #: _____ Relationship: _____

I understand that in the event of an emergency it may be necessary to give certain medical information to this contact.

This authorization shall remain in effect unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical records.

Signature of Patient or Legal Representative: _____

Printed name and relationship (if not patient): _____

Today's Date: _____

Patient Name: _____

DOB: _____

Consent to Treat

I hereby authorize employees and agents (including physicians, physician assistants, and nurse practitioners) of this medical office to render routine medical care to me, the patient indicated on this form and to fulfill the orders of the physicians (including consultants, associates, and assistants of the physician's choice.) I hereby authorize employees and agents of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians (including consultants, associates, and assistants of the physician's choice.) The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, medical care will not be provided except in a case of emergency.

Financial Responsibility

I hereby authorize payments from Medicare or other insurance companies of medical benefits directly to Dallas Internal Medicine and Geriatric Specialists and/or the attending physician for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services. I appoint Dallas Internal Medicine and Geriatric Specialists to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Dallas Internal Medicine and Geriatric Specialists. I further understand that should by account become delinquent, I shall pay the reasonable fees or collection expenses, if any. I acknowledge that I am fully responsible for supplying correct insurance information, billing information and payment of any services not covered or approved by my insurance carrier. The duration of this authorization is indefinite and continues until revoked in writing.

Release of Information

Authorization is hereby granted to release of information contained in my medical record as may be necessary for medical treatment or to process and complete my insurance claims. I understand that this release of information may include information regarding communicable diseases such as, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). The duration of this authorization is indefinite and continues until revoked in writing.

Financial Policies

I have read and received a copy of the financial policies for Dallas Internal Medicine and Geriatric Specialists.

Acknowledgement of Receipt of the Notice of Health Information Practices for Dallas Internal Medicine and Geriatric Specialists

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. Dallas Internal Medicine and Geriatric Specialists and associated physicians are committed to securing the privacy of your health information. We have made available to you a copy of the notice which provides information about how its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of Dallas Internal Medicine and Geriatric Specialists' Notice of Health Information Practices.

I have read all of the above and agree to these terms.

Signature of Patient/ Legal Guardian (if patient is a minor)

Date

Dallas Internal Medicine and Geriatric Specialists, PA

601 Clara Barton Blvd, Suite 145

Garland, TX 75042

AUTHORIZATION TO RETRIEVE MEDICATION RECORDS

I _____ authorize Dallas Internal Medicine and Geriatric Specialists to retrieve my complete medication profile from my insurance, pharmacy, or other third party source. I understand this information will be kept confidential and used only to aid in my ongoing treatment.

I understand this authorization will remain in effect until/unless I revoke it in writing.

Signature of Patient (or Authorized Representative)

Date