Texas Pulmonary and Sleep Clinic, P.A.
Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Texas Pulmonary and Sleep Clinic, P.A. appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

Non-medical charges: These services and charges are never reimbursed by your insurance plan therefore the patient is responsible for such payments.

- Returned checks- A charge of $50.00 may be issued for a returned check for treatment.
- Cancelled or missed appointments- Please give notice of at least 24 hours if you will not be able to keep your appointment.
- Requests for copies of medical records may have a fee of $25.00 unless the copies are formally requested by another physician's office or healthcare facility.
- Additional forms to be filled out by the physician as requested by the patient may have a fee associated with it.

I have read the above policy regarding my financial responsibility to Texas Pulmonary and Sleep Clinic, P.A., for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Texas Pulmonary and Sleep Clinic, P.A., the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Assignment of Benefits

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by Texas Pulmonary and Sleep Clinic, P.A.. I assign and authorize payments to Texas Pulmonary and Sleep Clinic, P.A. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law.

Patient Signature _____ **Date** _____

Guarantor Signature _____ **Date** _____
(If guarantor is not the patient)

Consent for Treatment and Authorization to Release Information

I hereby authorize Texas Pulmonary and Sleep Clinic, P.A., through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Texas Pulmonary and Sleep Clinic, P.A., to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

In addition to the above release, I authorize Texas Pulmonary and Sleep Clinic, P.A. to release any information to:

Please print name (s)

Spouse/Partner: _____ Parent: _____

Other: _____ None.

Patient/Guarantor Signature _____ **Date** _____

I wish to be contacted in the following manner (check all that apply):

Home Telephone: _____ Cell Telephone: _____

o
o Ok to leave message with detailed information
o
o Leave message with call-back number only

Work Telephone: _____ Other: _____

o
o Ok to leave message with detailed information
o
o Leave message with call-back number only