

Southwest Diabetes & Endocrinology

Explanation of Patient Financial Responsibility

We are committed to providing you the best available medical care. Our personnel will be pleased to discuss our fees and this policy with you at any time. Your clear understanding of our Financial Policy will enhance our professional relationship. Thank you for your review and acceptance of this policy

Payment is due at the time of service. This includes all co-pays, deductibles and co-insurance. **If your insurance company requires a referral, it is the patient's responsibility (or guarantor) to obtain the referral prior to your appointment.**

We accept cash, checks, debit cards and all major credit cards. If you are unable to pay the full copay, you will be asked to reschedule your appointment. Returned checks will be subject to a \$30 charge.

Please remember that our relationship is with you, not with your insurance company. Your insurance policy is a contract between you and your insurance company.

Please provide your health insurance information at the time of the visit. **As a courtesy, we will file your claim to your health insurance(s)/ Medicare.** Insurance will be filed for services rendered.

You are responsible for notifying our office of any changes to demographics or insurance and billing information. Please provide us with details of both primary and secondary insurance. **If you fail to provide us with the correct information at the time of services rendered, your insurance may deny the claim and you will be billed the full fees.**

Your health plan may refuse payment of a claim for any of the following reasons:

- Diagnosis is a pre-existing illness which is not covered by your plan.
- You have not met your full calendar year deductible.
- The type of medical service or diagnosis is not covered by your plan.
- The health plan was not in effect at the time of service.
- You have other insurance which must be filed first.
- We do not participate in your plan.

Any charges for services not covered by insurance will be the responsibility of the patient. I understand that it is my responsibility to know my insurance benefits and whether or not the services rendered are covered benefits.

Initial _____

Out of Network services not paid by the health insurance company will be the responsibility of the patient.

Any verification of benefits provided by your insurance carrier is not considered to be a guarantee of coverage. If your health plan denies a claim for any reason, it is your responsibility as a patient to pay the denied amounts in full.

It is your responsibility to keep your account with us current. This includes all outstanding balances due resulting from co-pays, deductibles, non-covered services, billing adjustments, etc. that are reflected in your Explanation of Benefits received from your insurance company and billing statements received from us. You must pay these outstanding balances in full prior to seeing the physician for your next appointment.

I hereby consent to credit bureau inquiries and to receiving auto-dialed/artificial or pre-recorded message calls, and/or text messages to my cellular telephone and to any telephone number provided during my registration process. I understand that these collection attempts could be performed by SW Endocrinology or its affiliates/agents including, without limitation, any account management companies, independent contractors or collection agents.

It is required that Self Pay patients with no insurance pay the full amount due at the time of service. If you are unable to pay the full amount at the time of service, we will ask you to reschedule your appointment.

I _____ have read and understand the above policies.
(Please print name)

Patient Signature _____ Date _____