The Center for Family Medicine, Wellness and Aesthetics, P.A.
Financial Policy

To our patients:

Thank you for selecting our office for your medical care. In order to prevent any misunderstanding concerning the responsibility for payment for medical services provided to our patients, the following information is supplied:

The patient or their guarantor is responsible for payment for services provided by **The Center for Family Medicine, Wellness and Aesthetics** at the time of service. The only exception is if **The Center for Family Medicine, Wellness and Aesthetics** has contracted with your HMO/PPO/POS or Medicare to accept the insurance payment as payment in full after all deductibles have been met and all co-pays has been paid.

We will furnish you with a copy of your bill at each visit, which contains all the information necessary for you to bill your insurance carrier. Charges for an office visit range from $10 to $200 +. Additional services such as laboratory maybe an additional charge and you will be billed separately.

HMO/PPO/POS or other Contracted Insurance Coverage:
If you have insurance coverage through a company that we have contracted with, we require a copy of your insurance card. Failure to provide this will result in your paying the full amount of the visit at the time of service. Payment of your deductible, co-payment and/or non-covered service is expected at the time of service.

MEDICARE:

Office visits to a doctor are covered under part B of the Medicare program. Medicare pays 80% of their **allowable** charges after **you pay your annual deductible** for the calendar year. If you have supplemental insurance we require a copy of your insurance card.

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS

In the event that my insurance company denies payment for services rendered, I accept responsibility for the payment due depending on my insurance company's contract with The Center for Family Medicine, Wellness and Aesthetics.

In the event that I am not covered by insurance, I understand that I am responsible for payment in full.

I hereby authorize The Center for Family Medicine Wellness and Aesthetics to release any information acquired in the course of my examination or treatment that may be necessary to process my claim. In consideration of services rendered, I hereby authorize payment, not to exceed reasonable and customary charges, directly to The Center for Family Medicine, Wellness and Aesthetics, P.A.(TXID# 203463015)

Patient Signature:_____ **Date:**_____

Responsible Party:_____ **Date:**_____