Lone Star Physicians Group, PA

FINANCIAL POLICY:

____ (Initials) All payments including co-pays, co-insurance, non-covered services, and self-insured payments are **PAYABLE AT TIME OF SERVICE,** unless prior arrangements have been made regarding the payments (**only established patients)**. **It is your responsibility to confirm if the services are covered under your insurance plan ahead of visit.** There is a discount available for self-insured patients who make prompt payments on day of service.

____ (Initials) We will bill your insurance company for services rendered. Accounts that are 30 days past due will be contacted for payment and accounts that are **90 days past due will be forwarded to collections.**

____ (Initials) As a convenience to our patients we accept credit cards (Visa, MasterCard, American Express and Discover) debit cards and personal checks are accepted. **Returned checks will be charged $45.00 in addition to fees that may charge by banking institutions.**

____ (Initials) **No shows or appointments that are not cancelled** at least 4 hours in advance are subject to a **$50.00 fee** that will reflect on your next bill and will be your responsibility.

____ (Initials) **Additional copies** of any records/documents will each have a **$5.00 charge.**

I have read and understand the above policy.

Patient or Patients Name: _____

Parent / Guardian Signature _____ **Date** _____

Revised 12/11/2018