FREDERICKSBURG FAMILY CLINIC, PA
d/b/a/ CORNERSTONE CLINIC

514 W. WINDCREST ST., FREDERICKSBURG, TX 78624, 830.997.0330
815 FRONT ST., COMFORT, TX 78013, 830.995.5633

Financial Policy

Thank you for choosing us as your primary care provider. We are committed to providing our patients with quality and affordable health care. To ensure that the physicians of Fredericksburg Family Clinic, P.A. d/b/a Cornerstone Clinic has financial stability and can continue to provide medical services to the community and region, the following credit policies shall be enforced. Please read this policy, ask us any questions you may have, and sign in the space provided. A signed copy of this form will be provided to you upon request.

PAYMENT RESPONSIBILITY: We understand that many patients expect their insurance company to pay for a large portion of medical claims. However, **the patient** (or legal representative of the patient) **is ultimately responsible for the bill if the insurance company does not pay.**

As a courtesy to you, we will file a claim to your primary and secondary insurance plans. Co-payments (e.g. Coinsurance, Deductibles, Non-Covered services, etc.) must be paid at the time treatment is provided. If you are unsure of your financial responsibility, please contact your insurance company in advance to obtain this information. Should you need to speak to a financial counselor to make payment arrangements prior to your scheduled appointment, please call a counselor at the Fredericksburg location at (**830)992.2705**, **(830)992.2706** or at the Comfort location at **(830)995.5633**. Any balance remaining after insurance has paid their part of the covered portion, will be due upon receipt of statement.

NON-DISCRIMINATION OF SERVICES: Necessary medical services for established patients will be provided regardless of patient's ability to pay.

PROOF OF INSURANCE: All patients must provide some form of **ID (driver's license or other photo id) and current valid insurance card to provide proof of insurance**. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

INSURANCE: We participate in most insurance plans, including Medicare and Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we are contracted with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

CO-PAYMENTS AND DEDUCTIBLES: All co-payments and deductibles **must be paid** at the time of service or your appointment may be rescheduled. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

NON-COVERED SERVICES: Payment for all charges that are not covered by insurance is due and payable at the time of service. A pre-treatment deposit may be required. If you are unable to pay the full balance due within 30 days after treatment is rendered, please see a financial counselor to discuss monthly payment arrangements.

NONPAYMENT: If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account 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 and your immediate family members may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, your healthcare provider will only be able to treat you on an emergency basis only.

PRIOR UNPAID ACCOUNTS: Prior to providing services, payment of prior outstanding accounts may be requested and should be received or specific payment arrangements made. If the balance cannot be paid in full, then you must speak with a financial counselor to make payment arrangements prior to your appointment.

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METHODS OF PAYMENT: We accept cash, check, VISA, MasterCard, American Express and Discover. We do **not** accept post-dated checks, nor will we hold checks for any length of time. Payment arrangements may be made as necessary by calling a financial counselor at the Fredericksburg location at **(830)992-2705, (830)992.2706** or at the Comfort location at **(830)995-5633**.

PAYMENT ARRANGEMENTS: If a patient is unable to make full payment of the patient balance when due, periodic, partial payments may be approved in accordance with credit and collections procedures, as authorized by the physician of his designee. Members of our billing and insurance department are always available to help you with questions and or payment arrangements. Once made in writing, agreements are binding. We consider payment by the patient for services rendered to be an important part of the patient's role in the patient/healthcare provider relationship. Prompt payment for services rendered is expected and failure to comply or respond to repeated communications from our office may result in discharge from the practice and/or involvement of an outside collection agency. A patient financial evaluation may be requested to determine appropriate payment arrangements.

WORKMAN'S COMPENSATION: Cornerstone Clinic does not currently accept workman's compensation at this time. Please contact your adjuster for a listing of approved providers.

MEDICARE PATIENTS: Cornerstone Clinic accepts Medicare assignment. We will bill your secondary insurance if you provide us the proper insurance information. You are responsible for the applicable coinsurance and deductibles, and charges for non-covered services. You should receive an explanation of benefits from Medicare indicating how much you owe.

MEDICAID PATIENTS: Cornerstone Clinic accepts Medicaid assignment. You will be required to pay any co-pay at the time of service, if required by your plan. If you have exceeded the legislative limits for the year as set forth by Medicaid, you will be held responsible for the charges.

THIRD PARTY LITIGATION: If you are involved in an accident we will be pleased to provide medical care for you. We do not, however, file claims with third-party liability insurance plans. We will either file the claim with your personal medical insurance or we will expect a deposit from you and payments from you for all balances incurred.

RETURNED CHECKS: There will be a $25.00 fee assessed for any and all checks returned from the bank for any reason. Uncollected checks may be submitted to the District Attorney for criminal prosecution.

CHARITY ALLOWANCES: If a patient is determined to be financially indigent, the financial counselor will assist the patient in applying for other financial assistance. If no source of financial assistance is available, the physician will review the account for a charity allowance. All charity allowance must be approved by the physician or delegated representative.

REFUNDS: Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patient refund will not be processed until all active or past due accounts associated with the patient are paid in full.

MINOR PATIENTS: For all services rendered to minor patients, the adult accompanying the patient is responsible for payment. Even if the parents are divorced the parent that accompanies the minor to the doctor is responsible for payment, regardless of the terms of the custodial agreement.

I have read and understand the financial policy of Fredericksburg Family Clinic, P.A. d/b/a CORNERSTONE CLINIC and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_______________________________ _______________ __________
Signature of Patient or Legal Representative of Patient   Patient's Date of Birth   Date

____
Printed name of Patient or Legal Representative of Patient

If representative, specify relationship to patient: ❒Parent ❒Guardian ❒Other_______________________