Plano Primary Care Clinic
Financial Policy

Patient Name: _____ Date of Birth: _____

BASIC POLICY: Pay for service is due in full at the time service is provided in our office.

FOR PATIENTS WITH INSURANCE: We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayment and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

MEDICARE PATIENTS: We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time service is provided.

WELFARE PATIENTS: All welfare patients must provide a current, valid sticker before being seen.

SURGERY FEES: All copayments, deductibles, and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.

NON-COVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

PERSONAL INJURY CASES: This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

WORKER'S COMPENSATION: If your injury is work-related, we will need the case number and carrier name prior to your visits in order to bill the worker's compensation insurance company.

YEARLY HEALTH CHECKS: Periodic preventative health checks may or may not be covered under you health insurance policy; however, that may be required by your physician.

MISSED APPOINTMENTS: In fairness to other patients and the doctor, we require at least 24 hours notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice.

OB FINANCIAL GUIDELINES: These are covered in our OB fact sheet.

Please check one: I have paid my insurance deductible for the calendar year Yes No I don't know

MEDICARE PATIENTS: SIGNATURE ON FILE I request payment of authorized Medicare benefits to be made either to me or on my behalf to PLANO PRIMARY CARE CLINIC for any services furnished my by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine there benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Name (Please Print): _____ **Provider**

Patient Signature: _____ **Muhammad M. Farooqi, M.D.**

Patient Medicare #: _____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS **(Patients with insurance please read and sign below)**

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to PLANO PRIMARY CARE CLINIC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not pain by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date: _____

I have read, understood, and agreed to the above financial policy for payment of professional fees. The patient is ultimately responsible for all professional fees.

Signature: _____ Date: _____