Susan C. King MD

1907 Cypress Creek Rd. Suite 104 Cedar Park, TX 78613

Patient Financial Responsibilities and Policies

Thank you for choosing the practice of Susan C. King, MD for your medical needs. The following patient financial responsibilities and policies have been established to assist us providing the highest quality medical care.

Insurance: It is your responsibility to know and understand your coverage and benefits. As a courtesy, we will file your insurance forms from our office. Please make sure your insurance and demographic information is kept up to date with our office. This includes any change of information such as address, phone numbers, and insurance changes. If the patient is not the policy holder on the insurance, we require the policy holder's full name, date of birth, social security number and relationship to the patient to file all claims. Patients are responsible for all fees at the time of service that are not covered by insurance, including co-payments, coinsurance, deductibles and non-covered services or items received. **At every visit, please make sure you have all insurance card(s) and photo identification as well as any other forms that may assist us in processing your claims correctly.**

No Insurance: If you are not covered by insurance at the time of service, please be advised that you will be responsible for all charges incurred at the time of service. Cash or credit card is accepted.

Returned Check: There will be a thirty-dollar ($30.00) charge assessed for any check returned by your bank for any reason.

Past Due Balances: Accounts that are not paid within sixty (60) days from the date of service may be sent to a third-party collections agency. A collection fee may be added to the balance. If acceptable terms cannot be reached to satisfy the past due balance, the patient may be dismissed from our practice.

Medical Records: If you request a copy of your medical records, you will be required to (1.) sign a medical record release form and (2.) pay a medical record fee prior to having your records copied (fee details stated on release form). Please allow up to 14 days for this request to be processed.

Refunds: If you have a credit on your account, we will gladly refund the amount within thirty (30) days of your request. You must provide a correct mailing address for your refund to be sent.

Dismissal Process: There are several reasons that a patient may be dismissed from our practice. A few reasons are as follows:

- Failure to keep scheduled appointments
- Being verbally or physically abusive to staff
- Failure to meet financial obligations

A certified letter will be sent to your last known address notifying you that you are being dismissed from our practice. If you have a medical emergency within thirty (30) days of the date of the letter, we will be available for advice. After the thirty (30) days, you will no longer be seen at our practice. A copy of your medical record may be forwarded to your new doctor after a formal request is made and applicable fees (if any) are paid.

Patient Acknowledgement:

I , _____ (print name) have read and agree to the **Patient Financial Responsibilities and Policies.** I agree to pay at the time of service. I also understand that Susan C. King MD reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I further agree to pay all reasonable costs and late fees should my account be turned over to collections.

_____

Patient's or Responsible Party's Signature **Date**

_____

Witness Signature **Date**