TEXAS KIDNEY PARTNERS

Patient Financial Agreement

1. **Insurance:** We process insurance claims as a courtesy to our patients. Estimated deductible and co-payment amounts based on your insurance benefits are due at the time of service. This amount may be subject to adjustment once the insurance claim(s) is processed by your insurance company. While we will try to provide the best estimate of insurance benefits and patient responsibility, your insurance plan and benefits ultimately determine the amount paid. It is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. You are responsible for monitoring your benefits. You are also responsible for advising us of any changes, and may not rely upon any information provided by our staff regarding your remaining benefit in any annual benefit period. To the extent that the claims we submit to insurance companies may indicate that you have assigned those benefits to our office, this document represents an assignment of benefits and claims related in any way to the medical services you receive or are entitled to. This document also represents your affirmative grant of consent for us to release information needed to process claims to all your insurance carrier(s) and its authorized agents as well as appeal any adverse decision rendered by your insurance company on your behalf. If you receive direct reimbursement from your insurance company instead of receipt by your provider, please note that you then become responsible for the total account balance and payment would be expected immediately. If you or your family has more than one health/medical insurance policy or program, we will assist you in obtaining the maximum benefits available. You, as a patient, are generally responsible for any charges that are not covered by your insurance.

2. **Payment Policy:**

- If you have health/medical insurance, your insurance claim will be processed as follows:
  - In Network: If your doctor is a participating provider in your insurance network, you will be billed according to the terms of your doctor's agreement with your insurer.
  - Out of Network: Payment in full will be collected at the time of service. As a courtesy, we will submit a claim to your insurance company on your behalf. Any allowed reimbursement will be sent to you directly from your insurance company.
- Minors accompanied by an adult: The adult accompanying a minor, his/her parents or guardians, are responsible for payment at time of service.
- Unaccompanied minors: The parents or guardians are responsible for full payment of any estimated amount at time of service. Non-emergency treatment may be denied unless charges have been pre-authorized to an approved payment plan, or accepted third-party financing.

3. **Forms of Payment:** Our offices accept Visa, MasterCard, Discover, and American Express, as well as Cash, Debit Cards, and Personal Checks for payment of services. Credit decisions are the responsibility of these third-party companies. You may choose to pay all or a portion of your treatment using approved forms of payment.

4. **Open Balances:** Accounts with open balances are due prior to your date of service. Should your account require the action of a collection agency, you would be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

5. **Missed Appointment Fee**: Patients who do not show up on time for an appointment, or fail to reschedule or cancel with less than 24 hours' notice will be charged a $25.00 fee. This charge will not be reimbursed by your insurance. Patients with three missed appointments may be asked to transfer their records to another doctor.

6. **Patient Communication:** We would like to keep in touch with you regarding upcoming appointments and treatment status. By providing your email address, phone number, and mailing address, you are giving us permission to contact you through these communication methods, including automated text and voice message systems. You understand that you may opt out of any automated message system at any time.
Acknowledgement of Financial Policy: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my health/medical benefits directly to my doctor's office. I understand that responsibility for payment for medical services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

____________________________	____________________________
Printed Name	Date
____________________________	____________________________
Signature of Patient (or authorized guardian)	If authorized guardian, relationship to patient