

## Financial Guidelines

Thank you for choosing North Texas Bariatric & General Surgery. We appreciate your trust and the opportunity to serve you.

*North Texas Bariatric & General Surgery* is a specialty office; therefore, co-pays may be higher. Payment of services by your insurance may be subject to prior approval in the case of obesity related health care. Please check with your insurance company to ensure that these services are a covered benefit. All balances not paid for by insurance for non-coverage of obesity related healthcare will be patient responsibility.

**OFFICE VISITS-** Payment for treatment is due at time of service to include co-pays, deductibles, and or any co-insurance amounts. We accept cash, checks, and for your convenience; American Express, Discover, Mastercard, and Visa.

All checks are converted to electronic debit through Telecheck unless prior arrangements have been made.

### **Surgery Fees-**

All co-insurance amounts and deductibles for the Lap-Band and any other elective surgeries are to be **paid two weeks prior to your surgery date.**

- Secondary insurance will be filed only if given prior to date of service.
- **All charges are your responsibility whether your insurance company pays or not.**
  - If insurance has not paid your balance within 45 days of date of service we may ask for the balance in full from you.
- All accounts with a balance over 30 days after payment from insurance, or from date of service if not covered by insurance, will be subject to a 1.25% interest fee monthly or no less than \$2.00/month until paid in full.
- We are a member of the American Credit Bureau, Inc and may forward balances that are past 90 days unless previous payment arrangements have been made.
- Additional fees may be applied to your total balance if the account is sent for further collections. These may include a fee of \$30.00 in addition to accumulated interest.
- Returned checks will be subject to a \$30.00 service charge.

**Cancellation Notice-** If you need to cancel or re-schedule an appointment please give us at least 24 hours notice in advance so that we may fill this spot. Our appointment times are very limited. You will be charged for missed appointments at the rate of \$25.00 if you have not rescheduled within this time.

We do understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

By signing below, you have agreed to all the terms listed above and will take responsibility for all payments as required by law.

I have read the terms and conditions listed above and agree to the financial responsibility and subsequent fees if the terms of financial agreement have not been met by me.

Signature: \_\_\_\_\_ Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/guardian of minor child \_\_\_\_\_ Date: \_\_\_\_\_