Plano Supreme Primary Care
Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Plano Supreme Primary Care appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

Please notify the clinic any changes in your insurance information and coverage.

Returned checks will be subject to a $30 fee. If we receive a returned check, we will no longer be able to accept checks from you in the future; cash and credit card will be the only method of payment accepted.

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Self-Pay

I do not have health insurance. I request my claims be submitted to my motor vehicle carrier. I understand I will be responsible for bills incurred by me in the event my PIP benefit exhausts or denies.

I have read the above policy regarding my financial responsibility to Plano Supreme Primary Care, for providing Medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Plano Supreme Primary Care, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient/Guarantor Signature _____Date _____

Consent for Treatment and Authorization to Release Information

I hereby authorize Plano Supreme Primary Care, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Plano Supreme Primary Care, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Acknowledgement of Notice of Privacy Practice

I hereby acknowledge that I have been presented with a copy of Plano Supreme Primary Care Notice of Privacy Practice and their Office Protocol handout and understand my responsibility. I acknowledge that I was presented with the Notice of Privacy Practices of Plano Supreme Primary Care.

Patient/Guarantor Signature _____Date _____