



## Jefferson Street Family Practice

1101 W. 40<sup>th</sup> Street  
Austin, TX 78756  
Phone: (512) 459-4147  
Fax: (512) 459-9134

### ***Our Financial Policy***

Thank you for choosing Jefferson Street Family Practice as your health care provider of choice. We are dedicated to providing the best possible care for you. Unfortunately, the cost of providing quality health care continues to rise as reimbursement rates decrease year after year. In order to stay in business, we find ourselves having to make some difficult decisions. As a result we have implemented this financial policy. Below we describe the financial policies of JSFP and we have outlined some useful information to help clarify our billing practices.

#### ***Patient Payments***

You may use cash, check, credit card, or debit card (with Visa or Master Card logo) to pay your account. Payment is required at the time of service for the following:

- ◆ Co-payments, as required by your insurance plan.
- ◆ High deductibles (a percentage of your deductible may be required, based on covered services)
- ◆ Non-covered services
- ◆ Lack of medical coverage

In the event that you wish to be billed for co-pays or other non-covered services a \$15.00 billing fee will be added to your account. Payment arrangements may be requested in cases of financial hardship.

#### ***Insurance Billing and Payments***

As a courtesy to you, we will bill your primary insurance company directly for medical services rendered. While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by your insurance is correct. We encourage you to call your insurance plan directly if you have any questions about covered services. In addition, you will be responsible for payment of all non-covered services at the time they are rendered. In the event that your insurance subsequently pays for services that were first treated as non-covered, you will be reimbursed.

*Please be advised that ultimately you are financially responsible for payment of medical services rendered by this office.*

#### ***Motor Vehicle Accidents (Third Party Payers) and Workers Compensation***

Our office does not bill third party payers such as PIP (Personal Injury Protection), or attorneys, for motor vehicle accidents. We will be more than happy to treat you, but please be aware this visit will be treated as non-covered service (see above). We also do not bill or file Workers Compensation claims.

#### ***Missed/ Late Cancelled Appointments***

Please give us at least 24 hours notification if you cannot keep an appointment. This courtesy will allow others to be seen. We do realize that emergencies arise and therefore do not charge for the first missed or late cancelled appointment. However, you will be charged \$25.00 for subsequent missed or late cancelled non-physical appointments and \$50 for routine physical appointments.

#### ***Returned Checks***

There will be a \$25.00 handling fee for returned checks. If a second check is presented that is returned from the bank, we will request that future visits be paid with cash, credit, or debit card.

#### ***Statements and Collections***

Statements will be sent out on the 15<sup>th</sup> of each month, payment is due upon receipt. If after 30 days payment is not received, your account may be subject to "Collections" and a fee of 25% of the balance due will be assessed. Please contact our Business Office to set up payment arrangements if necessary.

We welcome the opportunity to discuss any aspect of our financial policy. Please ask to speak to our Billing Office or Office Manager if you have any questions, comments, or concerns. We sincerely regret having to create such a policy and hope you understand our reasoning. We thank you for your support, and look forward to serving you in the future.

#### ***Patient Authorization***

I have read, understand, and agree to abide by the terms stipulated above. I request that payment of benefits be made to Jefferson Street Family Practice. I hereby authorize the release of any information necessary to determine liability for payment and obtain reimbursement on any claim. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be as valid as the original. This authorization shall remain valid until revoked by me in writing.

**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Patient Signature (or Responsible Party, if a minor):** \_\_\_\_\_ **Date:** \_\_\_\_\_