Katy Medical & Wellness
18400 Katy Freeway, Suite 590
Houston, Texas 77094
Phone (281) 492-1900; Fax (281) 492-1060
www.mykatymedial.com

OFFICE POLICY –PLEASE READ CAREFULLY

Payment is due at the time of service unless prior arrangements are made. We accept cash and credit card. Please note that there is a **$25.00** fee for all returned checks, a **$25.00** fee for missed appointments if the office is not notified 24 hours in advance of the office appointment, and a $25.00 charge for copies of medical records. This fee is waived if requested by another physician's office.

It is the responsibility of the patient to understand their benefits, referral needs, and coverage benefits. We will not assume financial responsibility if there is a mistake. We are providers for most insurance plans and will file insurance claims on your behalf. Co-payments and deductibles are due prior to seeing the physician at the time of service. You are responsible for requesting and ensuring all necessary referrals are in place prior to any specialist visits. You are also responsible for all non-covered charges. If your insurance does not make payments within 60 days, you may be asked to call on our behalf.

Frequently, insurance companies require additional information from the patient before processing a claim. If you receive such requests in the mail, please fill out the form and mail it to your insurance company as quickly as possible. Failure to do so will make you responsible for the entire bill regardless of your contract status. We will expect payment of deductibles and co-insurance amounts at the time of service or proof that your deductible has been met. We allow 60 days for processing of insurance claims, at the end of that time if your insurance has not paid, the entire balance becomes your responsibility.

Medicare*:* Katy Medical & Wellness will accept assignments for our Medicare patients. If you do not have a Medicare supplement and have not met your deductible at the time of service, we expect you to pay your 20%. We do not accept Medicaid plans. Please sign here that you have read this office policy and agree to it.

_____ _____
PATIENT'S SIGNATURE OR LEGAL GUARDIAN DATE

HIPPA POLICY OF COMPLIANCE

Please be sure that you have received a HIPPAA policy & compliancy form and have read over it completely. It is available at the front desk. Please sign below stating that you read over them, and understand them completely.

_____ _____
PATIENT'S SIGNATURE OR LEGAL GUARDIAN DATE

RELEASE OF INFORMATION

I hereby authorize ***Katy Medical & Wellness*** to furnish my medical information to any specialist(s) or insurance company for the purpose of obtaining payments. I further authorize any specialist(s) and other care providers to furnish all medical information concerning my health to ***Katy Medical & Wellness***. I agree to allow the faxing of this information when necessary.

_____ _____
PATIENT'S SIGNATURE OR LEGAL GUARDIAN DATE

ASSIGNMENT OF BENEFITS

I request payments of medical benefits otherwise payable to me be made to ***Katy Medical & Wellness*** for services provided by the group. I understand that I am financially responsible to ***Katy Medical & Wellness*** for charges not covered by the insurance.

_____ _____
PATIENT'S SIGNATURE OR LEGAL GUARDIAN DATE

CONCENT TO TREATMENT

I hereby authorize evaluation and treatment by ***Katy Medical & Wellness***. I understand and agree that the signature and duties on this form will not expire without written notice and that a photocopy of this form is considered valid as the original.

_____ _____
PATIENT'S SIGNATURE OR LEGAL GUARDIAN DATE