Third Coast Family Practice
Craig Matheson, D.O.

Payment Policy

1. Insurance: Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage and for all hospitalizations. Please refer to the list of insurances with which our office participates. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. Your insurance benefits are a contract between you and your insurance company; we are not a party to that coverage.

2. Co-Payments and Deductibles: All co-payments and deductibles must be paid at the time of service. A $10.00 surcharge will be added to your account if co-payments are not made at the time of service.

3. Non-covered Services: Please be aware that some and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. Patients are responsible for non-covered charges.

4. Self Pay and persons for whom office visits are a Non-covered service:
   - A 15% discount will be granted if payment in full is received on the day of service
   - At your 1st new patient visit a $70 deposit is expected prior to being seen by the doctor
   - Your account balance will be limited to $100 and must be paid in full within 30 days

5. Proof of Insurance: Patients are required to provide a copy of their current insurance card and a photo ID for our records. Patients agree to keep this information current.

6. Patient Balances: Monthly statements will be mailed to you notifying you of your patient balance. Payment is expected within 30 days. Payment plans are a courtesy that may be offered by the Finance Director if requested in advance. Partial payments will not be accepted unless previously negotiated. If your account is over 90 days past due, you will receive a letter stating that you have 15 days to pay your account in full or the account will be turned over to an outside collection agency. A 32% collection fee will be added to the balance of the account. Please be aware that an unpaid balance can lead to dismissal of you and your immediate family members from this practice. If this occurs, you will be notified by mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will refill your prescriptions and treat you on an emergency basis.

7. Fees: The following fees will be assessed:
   - FORMS- A $10 fee is required for completing forms in between office visits.
   - COPAY SURCHARGE- A $10 fee for failure to remit copay at time of service.
   - LATE PAYMENT- $5 fee for each 30 day period in which balance is not paid in full.
   - CHECKS RETURNED FOR NSF: $25.00
   - COLLECTIONS- 32% fee added to accounts sent to collections.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have questions or concerns.

I have read and understand the payment policy, and agree to abide by its guidelines:

_____ _____

Signature of Patient or Responsible Party Date