Las Colinas Obstetrics-Gynecology-Infertility Association, P.A.
6750 N. MacArthur Blvd., Suite 304
Irving, Texas 75039
Ph: 972-869-4488 Fax: 972-869-1220

Office Policy

Payment-Payment is due at the time of service. If you have insurance, your co-pay or percentage is due at the time of service, and/or your deductible needs to be met. We accept all credit cards, cash, checks, and third party financing.
Initials_____

Insurance-If we are your insurance's preferred provider, you must first meet your deductible and any part your insurance does not pay. Most misunderstandings about insurance can be avoided if you understand what your policy provides. If your insurance company chooses not to pay Las Colinas Ob/Gyn for whatever reason or they choose to delay payment, YOU will be responsible for payment. If payment is not received within 60 days from your insurance company, you will be charged. Payment is expected within one week of receipt of our invoice. The invoice will accrue an interest rate of 1.5% per month. This office will assist you as our patient or your Human Resources Department with any information, which may be helpful in the additional processing of your claim for insurance reimbursement. However, the stated policies regarding payment must be implemented because insurance companies have become more cavalier in the prompt processing of claims by physicians' offices. **Initials** _____

Insurance Authorization: I hereby assign Las Colinas Ob/Gyn all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance. **Initials** _____
Assignment of Benefits: I hereby assign Las Colinas Ob/Gyn all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance. **Initials** ____

Note: Commercial Accounts- We would like to inform you that we do not file claims for office visits or procedures under $200.00. (Exception for example: Managed Choice, HMO, Etc.). **Initials** _____

Delinquent Accounts- Delinquent accounts will be reported to our collection service. Please let us know if your payment will be late in arriving at the office. **Initials** _____
Returned Checks- There will be a $ 25.00 charge for all returned checks. After a check has been returned twice for NSF, payment will be on a cash basis only. **Initials**_____

Office Procedure /Surgery- When office procedures or surgeries are scheduled; a patient must speak with the business office to discuss charges and payment information prior to their appointment or surgery date. **Initials** _____
Cancellations- There will be a $ 20.00 charge for patients who cancel an appointment without giving 24-hour notice. There will be a $ 20.00 for NO Show patients. This appointment time could have been given to a patient in need.
Initials _____

Prescriptions- There will be a $ 10.00 charge for duplication or replacement of written prescriptions. **Initials** _____
Lab or X-Rays- Patients are financially responsible for any lab or x-rays ordered by your physician. Please contact your insurance company to verify your benefits if you have any questions. **Initials**_____

Thank you.

_____ _____/_____/_____
Patient Signature Date

Cc: Patient

Copy given to patient by _____
(Initial here)