A C M G

Alamo City Medical Group

Financial Policy

Thank you for choosing Alamo City Medical Group as your health care provider. ACMG is dedicated to caring for our community by providing excellent healthcare services and improving the quality of life to our patients and their families. Please understand that management of your billing is important in ensuring that we can continue to take care of your health care needs. The following is a statement of our "financial policy". Please read the information carefully and sign where noted below.

Unless other arrangements have been made in advance by either you or your health coverage carrier, full payment is due at the time of service. Payment may be made by cash, check, money order, or by Visa, MasterCard, Discover or American Express.

All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and a current, valid insurance card. Failure to provide a current, valid insurance card and/or information prior to your visit will result in payment due in full at the time of visit. Please bring these items to each visit.

We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any required copayment and deductible when you arrive for your appointment. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. In that event we will bill you and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you, on an unassigned basis. In this case, your insurer will send the payment directly to you. Therefore, charges for your care and treatment are due at the time of service.

We offer a 20% discount of the total billed charges to patients who pay in full at the time that service is rendered. The discount is available to any patient, unless their insurance policy or contract prohibits it. The discount only applies to ACMG standard fees, not to any contractually reduced fees.

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment or the subscriber/guarantor of the insurance plan.

Unpaid accounts may be referred to an outside collection agency. Also, please note that that there is a $25.00 return check fee.

Please notify us 24 hours in advance if you must cancel or change your appointment time.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

Signature of Patient or Responsible Party if a Minor Date

_____ _____

Patient Printed Name Date of Birth