



Payment Policy

Thank you for choosing Baylor Scott & White Family Health Center Richardson.

This policy will help answer questions on patient and insurance responsibility for services rendered at our clinic.

Insurance: We participate in most insurance plans, however new patient acceptance may vary by provider by insurance. All patients are required to provide an id or driver's license and valid insurance card. Co-payments, co-insurance, and deductibles are collected at time of service. If we are unable to verify coverage, payment in full may be required at time of service.

Non-covered services: Some services you receive may be non-covered or not considered reasonable or medically necessary by Medicare or other insurance carriers. You must pay for these services in full at the time of visit or when you receive notification from our billing office.

Claim submission: We will submit a claim for services to your insurance company. Your insurance company may need you to supply certain information directly to them. Please respond timely to ensure your claim is processed correctly.

Insurance changes: If your insurance changes, please notify us before your next visit so we can update your account and confirm coverage.

Patient Without Insurance – We offer a 30% discount to uninsured patients. All charges are payable at time of service.

Missed appointments: Baylor Scott & White Family Health Center Richardson reserves the right to charge a fee of \$25-\$50 for office visits, annual physicals or procedure visits that are not cancelled with a 24-hour advance notice. Charges for missed appointments are not covered by insurance and must be paid prior to next appointment. Multiple missed appointments or same day cancellations may result in discharge from our practice.

Knowing your insurance benefits is your responsibility. Please contact your insurance company directly with any questions you may have regarding your specific benefits.

I have read and understand the payment policy and agree to abide by its terms.

Signature of Patient or Responsible Party

Date

Medical Record Number