

PAYMENT ACKNOWLEDGEMENT STATEMENT

(Note: This form will need to be updated each year.)

Patient's

Full Name: _____ (_____)
FIRST MIDDLE LAST NAME KNOWN BY

The purpose of this form is to eliminate confusion about our payment and collection policies. Unless prior arrangements have been made, we expect payment at the time of visit. We accept cash, check, Mastercard, Visa, and American Express.

RETURNED CHECK FEE:

Any returned checks are subject to a \$30.00 service fee and must be resolved as soon as possible.

PPO NETWORK OFFICE CHARGES:

If we are a participating provider for your insurance company's PPO, we will file for your office visits in accordance with the requirements of your insurance plan, but we do not guarantee filing secondary claims, including Medicare supplement plans. Co-pays and deductibles (if applicable) are to be paid at the time of visit. If your insurance company decides to hold payment to us until they receive "additional information" from you, it is your responsibility to provide that information to your insurance company immediately. They are looking for ways to delay or to deny payment for your medical/surgical care. Statements will be sent for any remaining balance after your PPO plan pays its share (or declines to pay), and payment for the remaining balance is due upon receipt of the statement. If you are unable to pay the entire balance, please contact our office immediately to set up a payment plan. The minimum monthly payoff rate is established by the outstanding account balance at the time the payment plan is implemented. As long as we receive a payment each consecutive month, no interest charges nor collective actions will apply. Our minimum monthly payments are:

ACCOUNT BALANCE	MINIMUM MONTHLY PAYMENT	ACCOUNT BALANCE	MINIMUM MONTHLY PAYMENT
\$0.00 - \$100.00	\$25.00	\$751.00 - \$1,000.00	\$175.00
\$101.00 - \$250.00	\$50.00	\$1,001.00 - \$1,500.00	\$225.00
\$251.00 - \$500.00	\$75.00	\$1,501.00 - \$2,000.00	\$300.00
\$501.00 - \$750.00	\$125.00	\$2,000.00 +	\$375.00

Failure to respond to three statements requesting payment will cause us to begin collective action with either a collection agency or an attorney, in which case you will be responsible for interest at the statutory rate prescribed by the State of Texas, as well as attorney fees and court costs. Bad debts are reported to the appropriate credit bureaus.

HOSPITAL AND SURGERY CHARGES:

We do file insurance claims for orthopedic care provided by Thomas J. Parr, MD, PA outside our office, including emergency care and surgery. You will be responsible for paying any balance remaining after your insurance company's payment is received or after 60 days from the date of service, whichever comes first (see above in PPO Network Office Charges for details). If you are scheduled for surgery, you should contact your insurance company as soon as you can. It is not possible for us to know all of the special requirements within each patient's unique health insurance policy in order to have the insurance cover the costs of surgery.

DIVORCE SETTLEMENTS:

We are not a party in divorce settlements. The parent who brings a minor child for care will be the one responsible for paying us. If the other parent needs to reimburse you, we will give you a receipt as proof of your payment.

I have read and understand the above financial policy of Thomas J. Parr, MD, PA, 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: _____ Date: _____

(Federal Law requires this Truth in Lending Statement to be signed by the patient or guarantor.)