Allergy
Rheumatology
Immunology
Associates of **N**orth **T**exas-
ARIANT, PLLC

Financial Policy

We appreciate your trust in us and the opportunity to serve you. As part of our practice, we try to offer efficient and helpful billing services. To this end, we ask you to read the following statement of our financial billing policy**.** Please sign it prior to seeing the physician for your exam and/or treatment**.**

Patient payment responsibilities
Please bear in mind that it is your responsibility to pay as a deposit any deductible amount, co-insurance, co-pay or any other balance not covered by your insurance company prior to receiving services. Even though we assist you in receiving reimbursement from your insurance company, please understand that you, the patient, ultimately have the final responsibility of your bill. Additionally, we cannot waive copays for our patients since this is an insurance plan requirement.

Self Pay
All self-pay patients are required to pay in full, before seeing the physician for your exam and/or treatment**.**

Cancellation of Scheduled patient Appointments and Procedures
Our office requires prior notification of minimum of 48 Hrs for rescheduling/cancelling of patient appointments. Any follow-up rescheduled/cancelled appointment with less than 48 hours notice will be billed a fee of $40.

Payments
Bills will be issued after the insurance company pays its portion of the bill. We do require all guarantors to provide their social security numbers during the patient registration. Balances are due in full 30 days of when the bill is issued to you. We do not have the ability to carry patient balances over any extended period. We accept cash, checks, and most credit cards as forms of payment.

Our practice is committed to providing the best care for our patients. Our charges are within the usual and customary range for the medical specialties and for this area.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understood, and agreed to this Financial Policy.

_____ _____

Patient Signature *Date*

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