SOUTH MAIN CLINIC, INC
Medical Group
12333 S. Main Houston, Texas 77035
Phone: (713) 729-7600 Fax: (713) 729-7603

Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fee with you at any time. Your clear understanding of our FINANCIAL POLICY is important to our professional relationship. Please ask if you have any questions about our fees, FINANCIAL POLICY, or you responsibility.

- All patient must complete this form before seeing the doctor
- Full payment is due at the time of service
- We accept Cash, Checks, Visa, MasterCard, Discover, and American Express
- To remain in compliance with the term of you HMO/PPO, we must collect your co-payment at the time of your visit

If you have insurance, we will help you receive the maximum benefits. We will be pleased to help you process your insurance claim form for your reimbursement. A complete insurance claim form must accompany any such request at each visit. In special instances we may accept assignment of insurance benefits.

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.
We realize that temporary financial problems may affect timely payment of your account. If such a problem does arise, we encourage you to contact us promptly for assistance in the management of your account. Returned checks will be subject to additional fees, and after 10 days they will be filed with the Hot Check Division. Appointment non-cancelled within 24 hrs in advance will be subject to $25 fee. _________

If you have any question about the above information or uncertainty regarding insurance coverage, please do not hesitated to ask us. We are here to help you. PLEASE REMEMBER TO BRING YOUR INSURANCE CARD WITH YOU TO ALL OF YOUR APPOINTMENTS.

Please initial that you have read and understood the financial policy of SOUTH MAIN CLINIC, Inc. _______

IN ORDER FOR US TO FILE YOUR INSURANCE, YOU MUST SIGN ITEMS 1 AND 2 BELOW.

1. RELEASE OF INFORMATION
   I authorize the release of may medical information necessary to process an insurance claim. I also request payment of government or medical benefits to myself or SOUTH MAIN CLINIC, INC. If assignment is accepted.

Signature of Patient: ____ Date: ____________________

2. Authorization for payment benefits
   I authorize payment of medical benefits to South Main Clinic, Inc.

Signature of insured or authorized person _____________________________ Date: _______________