



**COASTAL BEND PRIMARY CARE**

**JESSE G GARCIA, M.D.**

**4621 S STAPLES**

**CORPUS CHRISTI, TX 78411**

**PHONE:(361) 654-0050 FX:(361) 654-0056 FX:(361) 654-0057**

**Practice Guidelines and Patient Financial Policies**

\_\_\_ **Emergencies:** Our providers will make the effort to receive your calls and respond promptly in an emergency. If you do not receive an immediate response you will call 911, receive paramedic intervention, and seek the nearest emergency room.

\_\_\_ **Prescription Refills:** It is our policy that you should be responsible to know when your medications must be refilled at least a week before you run out. Medications are refilled only at the patient visit or when requested in advance through your pharmacy. This includes all mail-order prescriptions. We cannot take weekend, walk-in, after hours, or phone call refill requests.

\_\_\_ **Telephone Encounters and Sick Patients:** Our practitioners do not treat new patients or new illnesses over the telephone. The physician may elect to treat an existing patient seeking continuing care for an existing straightforward illness over the phone. Such consultations are provided at a fee of \$35. Most insurance companies do not cover the costs for these encounters. Payments for these services are your responsibility.

\_\_\_ **Information:** You agree to provide your correct name, current and correct address, cellular or other phone number, email address, insurance information, Social Security number, driver's license, or picture identification at the time of registration or as requested by the practice at any time.

\_\_\_ **Financial Responsibility:** By these initials and your signature below, you accept financial responsibility for all charges for services rendered to you. If a minor or under guardianship, the parent or guardian accompanying the patient assumes this liability.

\_\_\_ **Payment Methods:** We accept cash, check, and several major credit cards. Reception staff may be contacted regarding credit cards accepted or insurance companies in which the practice participates.

\_\_\_ **Appointments:** Our office will schedule appointments as a common courtesy for patients and in consideration of your time. Minors must be accompanied by a parent or guardian to be seen unless special arrangements have been made with the office. We require a minimum of 24 hours [or the Friday before Monday appointment] notice of cancellation as a courtesy to other patients seeking services. A fee of \$50 will be charged for non-cancelled and missed appointments. A pattern of non-cancelled missed appointments may result in discharge from the practice.

\_\_\_ **Forms Fees:** Our practice charges for additional paperwork outside of the completion of the medical record. The following fees apply and are subject to change without notice: (a) duplicate prescriptions, orders, or referrals- \$25; (b) single page forms- \$25; (c) multi-page forms- \$50; (d) FMLA, immigration, disability, and driver's license forms- \$75. Additional fees may apply at the discretion of the practice and upon notification to you.

\_\_\_ **Medical Records:** The medical chart is the property of the practice. However, copies of your pertinent medical information are available upon request. The practice charges a fee for a copy of the

record according to those published annually by the State of Texas Comptroller's Office. This fee schedule is available upon request.

\_\_\_ **Insurance Copayments, Deductibles, and Coinsurance:** Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All copayments, deductibles, coinsurance, or non-covered services are to be paid in a timely fashion according to the office policies. If requested, and as a condition of service, you agree to sign an "advanced beneficiary notice" if we determine or question your insurance coverage. You accept responsibility for all such expenses even if your insurance company is billed as a courtesy.

\_\_\_ **Usual and Customary:** Some insurance plans may indicate that our fees are above "usual and customary." As a result your plan may reduce our fee to an "allowed amount" before calculating payment. This practice does not recognize a specific carrier's use of these terms. As such, unless we have specifically contracted with the carrier, it is expected that you will be liable for our full fees.

\_\_\_ **Slow Insurance Response:** You agree that if your insurance company takes more than 60 days to respond to your insurance claim that shall consider your services your financial responsibility and it will be your responsibility to seek reimbursement from your insurance company.

\_\_\_ **Accident & Worker's Compensation:** Although our office is happy to treat your medical conditions, if the cause is related to an auto or work-related accident you will be required to pay the full fees at the time of your visit.

\_\_\_ **Statement Policy:** Our office sends patient statements each month. Payments are due upon receipt of the statement. You understand that if we participate with your insurance company the sending of the statement may be delayed until your insurance responds to a claim for services. Such a delay can take months. You understand that such a delay does not alter our policy of patient financial responsibility and you will be liable for all service fees. A late fee may be charged for a patient balances due that are more than 30days old.

\_\_\_ **Collection and Bank Fees:** Accounts more than 90 days are old are subject to transfer to an outside collection agency. These agencies charge fees. You agree to be liable for all such collection expense, legal fees, and court costs. In addition, banks charge for checks that do not clear or cannot be cashed. You agree to be liable for all such fees with a minimum charge of \$35.

\_\_\_ **Patient Discharge:** The practice reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with treatment plan(s) as outlined by your practitioner.

\_\_\_ **Insurance Claims:** If applicable, our office will submit insurance claims. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. In the event your insurer sends payment for a claim from our office to you directly, you agree to endorse the payment to our practice in fulfillment of any amounts due within 10 days of postmark.

**I have read and understand all terms of this policy and by my initials and my signature below, I attest that I fully understand each item and agree to the terms above.**

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**Patient Printed Name**

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**Date**

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**Signature of Patient/Parent/Guardian**