☐ **Plaza Medical Centre**
700 N Pearl St, Suite N208
Dallas, TX 75201
Tel: (214) 999-9355

☐ **Griego Family Medical Centre**
2701 S Hampton Rd, Suite 101
Dallas, TX 75224
Tel: (214) 330-9221

FINANCIAL POLICY

All patients must read and sign this form prior to receiving services.

Thank you for choosing Metroplex Medical Centres as your health care provider. We are committed to the successful treatment of your condition. Your clear understanding of our Financial Policy is important to our relationship.
Please call our billing department if you have any questions, they may be reached at (214)580-7277.

INSURANCE (PPO/POS/Commercial/Medicare Advantage Plans): All co-payments or co-insurance is due at the time of service. We are members of most, but not all, plans. You are responsible for verifying that we are providers for your plan. You are responsible for co-payments, deductibles and co-insurances on your plan. We maintain the right to collect payment towards patient responsibility prior to any treatment. If applicable, you will be directed to speak to a patient representative. You are responsible or any service denied by your insurance as a non-covered service.

HMO INSURANCE: All co-payments are due at time of service. We will assist with referrals as directed by your plan.

MEDICARE: We do accept Medicare assignment. As a Medicare patient, you are responsible only for the difference between the approved amount and the amount that Medicare pays, and of course, your deductible. If you have supplemental insurance, please provide a copy of the card and we will bill it for you. You will receive a bill after your insurance has paid if there is any remaining balance.

SELF PAY: Payment is due in full at the time of service. If you are unable to pay your balance in full, you must see a patient representative to make other arrangements.

TREATMENT FOR A MINOR CHILD: A parent or legal guardian must accompany patients who are minors (under 18 years of age). This accompanying adult is responsible for payment of the account, according to policy outlined above.

RETURNED CHECK: A $35.00 charge will be added to your account for any check returned by your bank for any reason.

DISABILITY & INSURANCE FORMS: There will be a charge of $40.00 for the completion of medical / disability / FMLA forms. Payment is due before paperwork is processed.
Please allow 7-10 days for completion of these forms.

LAB SERVICES: The office bills only for services performed by our providers. Laboratories are separate entities and will bill you or your insurance company for services that are performed. If you have any questions about your laboratory bill please contact them or your insurance company directly.
It is your responsibility to provide us with your most current insurance information.

BEFORE RECEIVING SERVICES, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.

COPAYMENTS, COINSURANCE AND/OR DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.

STATEMENTS: We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. **You can call (214) 580-7277. Payment in full is due upon receipt of the statement.** If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.

Failure to keep your account balance current may require us to cancel or reschedule your appointment.
Full payment is due at the time of service. We accept cash, checks and credit cards.
I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed to ensure payment for services rendered to me. I understand that I am ultimately responsible for payment of all services.

Patient Name: _____

Patient Signature (or Responsible Party): _____ **Date:** _____