Houston Methodist Orthopedics & Sports Medicine Financial Policy

The following information is provided to avoid any misunderstanding or disagreement

concerning your payment for professional services:

- Prompt payment allows us to control costs. Outstanding accounts cost both of us time and money; therefore, all patients will be required to establish financial arrangements for payment of their account.
- All patient accounts are due and payable when services rendered
- Those patients without insurance coverage are required to pay in full at the time services are rendered.
- It should be mentioned that your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your claim and insure your carrier remits payment. If a problem occurs with your claim, you will be required to establish written financial arrangements with our practice until your insurance problem is resolved.
- Each month you will receive a monthly statement for services, which is due and payable within 30 days. If your payment is late, or if you have not previously made financial arrangements, then we will mail a reminder notice indicating there is a problem with your account. If you are experiencing a set of circumstances out of your control, please call our practice and we will be happy to make special arrangements.
- All patients refusing to remit payment after 60 days of notice without pending insurance or financial arrangement will force us to limit their future credit until the previous balance is paid in full or written financial arrangements are accomplished.
- All patients will be required to sign a written legal agreement with our practice to alleviate any current delinquency. Please notify us immediately if a mistake appears on the statement.

Houston Methodist Orthopedics & Sports Medicine firmly believes that a good doctor/patient relationship is based upon understanding and open communications. We have instructed our staff to make every effort available to you to clarify any misunderstanding you have concerning your balance. We hope to possibly avoid any disagreement over payment for professional services.

If you have any questions concerning our policy or need assistance please contact us immediately.

If you would like a copy of this form please ask.

Signature of Patient or Guarantor: ______________________________ Date:__________________

Witness:____ Date:__________________