## PAYMENT ACKNOWLEDGEMENT STATEMENT (Note: This form will need to be updated every year)

Patient's Full Name:			
First	Middle	Last (Name Known By)	
The purpose of this form is to eliminate confusion about our payment and collection policies. Unless prior arrangements have			
been made, we expect pay	ment at the time of your visit. We ad	ccept cash, check, all major Credit Card	S.
RETURNED CHECK FEI	E:		
Any returned checks are su	ubject to a \$25.00 service fee and mu	ist be resolved as soon as possible. Any	unresolved payments will
	Attorney's office for collection.	·	• •
	·		
PPO/HMO NETWORK OF	FICE CHARGES:		
If we are a participating provider for your insurance company (PPO or HMO), we will file your office visits in accordance with			
the requirements of your insurance company. Co pays and deductibles (if applicable) are to be paid at the time of your visit. If			
your insurance company decides to hold payment to us until they receive "additional information" from you, it is your			
responsibility to provide that information to your insurance company immediately. They are looking for ways to delay or deny			
payment for your medical care.			
Statements will be sent for any remaining balance after your PPO or HMO plans pays its share (or declines to pay), and payment			
for the remaining balance is due upon receipt of the statement. If you are unable to pay the entire balance, please contact our			
office immediately to set a payment plan. The minimum monthly payoff rate is established by the outstanding account balance			
at the time the payment plan is implanted. As long as we receive a payment inconsecutive months; no interest charge or			
collective actions will apply.			
Our minimum monthly p	payments are:		
	,		
Account Balance	Minimum Monthly Payment	Account Balance Minimum Mon	thly Payment
Account Bulance	William Worlding Faymene	7.ccodire balance William Work	iciny i dymene
\$ 0.00 - \$ 100.00	\$ 50.00	\$ 501 00 - \$ 750 00	\$125.00
\$ 101.00 - \$ 300.00	\$ 75.00	\$ 501.00 - \$ 750.00 \$ 751.00 - \$1,000.00 \$ 1,001.00 - \$2,000.00	\$150.00
\$301.00 - \$ 500.00	\$ 100.00	\$ 1,001,00, \$2,000,00	\$ 175.00
\$301.00 - \$ 500.00	\$ 100.00	\$ 1,001.00 - \$2,000.00	\$ 1/5.00
- 1			
Failure to respond to three statements requesting payment will cause us to begin collective action with either a collection agency or attorney, in which case you will be responsible for interest at the statutory rate prescribed by the State of Texas, as			
=			by the State of Texas, as
well as attorney fees and c	ourt cost. Bad debts are reported to	the appropriate credit bureaus.	
HOGDIMAL GHADGEG			
HOSPITAL CHARGES:			
We do not file insurance claims for medical care provided by our physicians outside our office, including emergency care and			
hospitalization. You will be responsible for paying any balance remaining after your insurance company's payment is received			
or after 60 days from the d	ate of service, whichever comes first	t.	
DIMODOE CEMBI EMENI	mc		
DIVORCE SETTLEMENTS:			
We are not a party in divorce settlements. The parent who brings a minor for child care will be the one responsible for paying us. If the other parent needs to reimburse you, we will give you a receipt as proof of your payment.			
us. If the other parent need	ds to reimburse you, we will give you	i a receipt as proof of your payment.	
The content of the characteristic and the cha			
I have read and understood the above financial policy of Sugar Land Med-Ped Clinic, P.A. / Subodh Bhuchar M.D. and I agree to			
be bound by its terms. I also understand and agree that such terms are subject to change at any time designated by the			

SUGAR LAND MED-PED CLINIC SUBODH BHUCHAR, M.D. 3533 Town Center Blvd Suite 100 Sugar Land TX 77479

\_ Date: \_\_

Telephone: 281-491-2555 – Fax 281-491-2554

(Federal Law requires this Truth and Lending Statement to be signed by the patient or guarantor)

practice.

Signature: \_\_\_\_