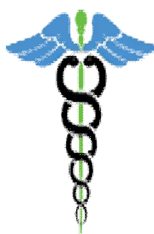

Advanced Gastroenterology of Texas

2698 N GALLOWAY PARKWAY
SUITE 103
MESQUITE, TX 75150

9 MEDICAL PLAZA 4, SUITE 206
DALLAS, TX 75234

Phone (214) 962-4863
Fax (214) 758-1400

www.advancedgastrodoc.com

AGREEMENT OF PRACTICE POLICIES

Thank you for choosing Advanced Gastroenterology of Texas, PLLC, the office of Farbod Masrour, D.O., as a partner in your health care. We are dedicated to ensuring you receive excellent care while you are our patient. As a part of our professional relationship, it is important you have an understanding of policies pertaining to the practice.

PLEASE READ EACH SECTION CAREFULLY. BY SIGNING THIS AGREEMENT, YOU ARE STATING YOU UNDERSTAND AND AGREE TO THE TERMS LISTED. ALL PATIENTS MUST COMPLETE THIS FORM PRIOR TO RECEIVING CARE. AS ALWAYS OUR OFFICE IS AVAILABLE TO ANSWER ANY QUESTIONS OR CONCERNS YOU MAY HAVE.

- ***IT IS MY RESPONSIBILITY TO PROVIDE THE PRACTICE WITH MY CURRENT INSURANCE INFORMATION.***

  - We must emphasize that as a medical provider our relationship is with you, the patient, and not your insurance company. **You are responsible for knowing and understanding the services covered by your plan.**
  - Copays, deductibles, and/or coinsurances are due at the time of service. The practice will estimate the amount owed based on information we receive from your insurance. Any additional amounts due after your insurance processes your claim will be billed to you.
  - Determining your amount owed consists of; your benefits with your insurance, our contractual obligations, and usual and customary rates in our area. In the event your insurance determines our rates exceed their arbitrary determination of usual and customary rates; you will be responsible for the additional amount not covered by your insurance.
  - It is your responsibility to notify the practice of any changes in your insurance in a timely manner. A delay in notifying the practice may result in a denial of your claim; and you will be fully responsible for any services not covered.
  - Your insurance may require referrals or prior authorization before services are rendered. It is your responsibility to know the requirements of your benefits. Any services denied for lack of notification to your insurance and/or penalties applied to our claim will be your responsibility.
  - If you have Medicaid coverage of any kind, you must notify us prior to your visit. This is a part of your agreement with Medicaid. Failure to notify us of Medicaid coverage may result in nonpayment from Medicaid; and you will be financially responsible for all services rendered.

- ***IT IS MY RESPONSIBILITY TO PROVIDE THE PRACTICE OF MY CURRENT BILLING INFORMATION.***

  - You must maintain your current billing address, telephone numbers, and any important contact information. You are responsible for contacting us to update this information if there are any changes.
  - A statement will be mailed, to the billing address provided, notifying you of any balance you may owe. If you have any questions or concerns regarding your statement, you may days from the initial statement.
  - call our billing office at (817) 731-6121. It is your responsibility to contact them within 30 If you are unable to pay the balance in full; you are responsible to make arrangements with our billing office. Any balances that remain unpaid after 30 days without prior arrangements will be considered past due. Past due accounts may be referred to a

professional collection agency and/or attorney for further collection activity. You will be subject to all fees imposed by outside collections.

- In the event the practice receives a personal check returned for nonsufficient funds; you will be required to pay a $25 fee in addition to your original balance. We may also seek all additional legal remedies provided to us under Texas law.
- Failure to keep your balance current may require the practice to reschedule or cancel your appointment until payment is received.

❖ ***IT IS MY RESPONSIBILITY TO RESCHEDULE OR CANCEL MY APPOINTMENT IN A TIMELY MANNER.***

- Appointments are scheduled to accommodate all of our patients and their needs. We require a 24-hour notice prior if you are unable to keep your appointment.
- We understand that unpredictable events happen and request you notify us as soon as you are aware of your inability to keep your appointment. You may or may not be subject to the “No Show” fee. The practice will review on a case-by-case basis.
- A fee of $50 will be charged to your account for failure to notify the practice of your need to reschedule or cancel without a 24-hour notice. The fee applies to procedures/surgeries scheduled as well. You will be fully responsible for the charge as the amount is not subject to being billed to your insurance. This applies to all insurance plans including Medicare and Medicaid.

❖ ***IT IS MY RESPONSIBILITY TO NOTIFY THE PRACTICE OF REQUESTS FOR MY MEDICAL RECORDS IN A TIMELY MANNER AND TO PAY FOR COSTS FOR CERTAIN USES.***

- Your medical records are the property of the practice. However, you may request copies as described in our Notice of Privacy practices.
- A written request to forward your records to another healthcare provider requires a 48-hour notice. The records must be mailed or faxed directly to the provider to avoid the charge for medical records.
- Forms that require information from our practice such as short-term disability claims, FMLA, etc are subject to a $25 fee. We also ask you give at least one week to complete the forms. Records required for SSI **are not** subject to the fee; and the records are mailed directly to the SS office.
- If you are requesting a copy of your records for your personal use; the following applies:
    - You must request the information in writing.
    - You must give a 48-hour notice.
    - Based on the Texas Medical Board ruling regarding fees for copies of medical records; the following fee for copies of your medical records applies:
        - $25 fee for the first 25 pages and an additional $.50 (each) for pages 26 and over. The fee applies to paper copies OR electronic copies.
        - If you request a paper AND electronic copy of your records, the fee will be:
            - Paper copy - $25 fee for the first 25 pages and an additional $.50 (each) for pages 26 and over.
            - Electronic copy - will be a set $35 fee.

❖ ***IT IS MY RESPONSIBILITY TO KNOW THE PRACTICE MAINTAINS THE FOLLOWING:***

- After normal business hours, you may contact the office regarding an urgent matter and leave a voicemail. However, the office may not have access to your voicemail immediately. If you have an urgent matter that needs your immediate attention, please contact or proceed to your nearest emergency room.
- If you need a refill on a prescription, you are responsible for contacting the pharmacy and have the pharmacy request the refill from the practice. Please submit your request to your pharmacy at least a week in advance before you run out to ensure you are not without your medications. We are unable to respond to request after hours, over the weekend, or holidays.
- The practice is unable to treat new patients or new illnesses over the phone. If you are experiencing new problems, you are responsible for contacting the office to schedule an appointment during normal business hours.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE PRACTICE POLICIES. AS A PATIENT OF ADVANCED GASTROENTEROLOGY OF TEXAS, PLLC, I AGREE TO THE TERMS AND I UNDERSTAND THAT AT ANY TIME THE PRACTICE HAS THE RIGHT TO DISCHARGE ME AS A PATIENT BASED ON MY FAILURE TO COMPLY WITH THE ABOVE POLICIES. IN ADDITION, THE PRACTICE ALSO HAS THE RIGHT TO DISCHARGE ME AS PATIENT FOR MY FAILURE TO COMPLY WITH TREATMENT PLANS GIVEN BY THE PHYSICIAN OR CLINICAL STAFF; INAPPROPRIATE CONDUCT TOWARDS OUR PHYSICIAN OR PRACTICE STAFF, OR ANY REASON DETERMINED BY THE PRACTICE. THE PRACTICE WILL NOTIFY THE ME BY CERTIFIED MAIL FOR ANY AND ALL REASONS OF DISCHARGE.

____ _______________________

Print Patient Date

____ _______________________

Signature of Patient of Legal Guardian Relationship