The Family Doctors
8383 Millicent Way Shreveport, La 71115
(318) 797-6661 Fax (318) 795-8512

Financial Policy

For all medical services provided in this office, inclusive of diagnostic laboratory testing and/or radiology studies, payment is due at time of service. Unless other arrangements have been made in advance with our Business Office, payment is expected upon check-in by cash, personal check (with proper identification) or credit card (VISA, MasterCard, Discover, or American Express).

For our patients with medical insurance coverage, the appropriate copay, deductible or co-insurance is due at time of registration.

For self pay patients, services exceeding $50 on the same day, a 15% cash discount may be given for payment in full with cash or check. If you pay your services by check and the check is returned by the bank or financial institution, all discounts will be added back to your account. You will also be assessed a returned check fee.

In a divorce or separation case where a child is being treated, regardless of who has been awarded custody or financial responsibility for the child, the person bringing the child for treatment is responsible for payment of services rendered.

When patient insurance is confirmed, The Family Doctors will file the remaining claim amount to the patient's insurance primary and secondary carrier only. After your insurance(s) has processed the claim, all remaining amounts after contractual adjustments shall be patient responsibility and due in full. When the patients insurance fails to respond to a properly filed claim in 30 days after our submittal, any remaining amounts shall be patient responsibility and due in full.

Patients with account balances will receive a monthly statement of activity. Payment in full is due upon receipt of the monthly statement. Payment arrangements may be available on a case by case basis. Contact our Business Office with your specific request.

We will make every effort to work with you and your insurance carrier, if applicable, to keep your account current. If circumstances of non-compliance and/or non-cooperation persist, we reserve the right to take whatever legal or other action that is necessary to bring your account current, including but not limited to outside collection proceedings and/or termination from our practice. All accounts over 180 days will go to collections.

Miscellaneous Fees may be added to your account as follows:

- $95 – Missed "confirmed" appointment without at least 24 hour notice before scheduled start
- $25 – After hours calls made to our on call Physician
- $25 – Returned check fee
- $30 – Family Medical Leave Act (FMLA) Form
- $15 – Patient requested form requiring direct supervision of a Physician outside of an appointment
- $ 5 – Processing and Handling fee for collection letters

These fees may change without notice to the patient.

Assignment of Benefits

I authorize payment for services be made directly to The Family Doctors which may be otherwise payable to me from all sources including but not limited to my medical insurance, my employers workers' compensation carrier or other parties for surgical/medical benefits with whom I have contracted. Such benefits will not exceed The Family Doctors billed charges for these services. I understand that I am financially responsible to The Family Doctors for charges not covered by this assignment and will adhere to the financial policies of The Family Doctors in the collection of these charges. I accept full responsibility for providing The Family Doctors accurate and complete information needed for their assisting me in processing my claims for reimbursement of medical services. I authorize the refund of overpaid insurance benefits where my coverage is subject to coordination of benefits.

Consent for Treatment

I hereby authorize and direct The Family Doctors physicians together with associates and assistants of their choice to administer or perform medical treatment on the patient identified, including any additional procedures/services as they deem necessary or reasonable, including but not limited to the administration of injections, x-ray or other radiological and laboratory services. I also hereby authorize the release of medical records to referring physicians and to my insurance companies for the purpose of payment, treatment and healthcare operations. This authorization for consent to medical treatment or surgical procedures is and shall remain valid until revoked.

Privacy Practices

I hereby acknowledge the offer and/or receipt of The Family Doctors Notice of Privacy Practices and been provided an opportunity to review them.

I have read, understand and agree to all of the above listed policies and practices.

_____ _____
Patient Name (printed) Date of Birth

_____ _____ _____
Patient/Guarantor Signature Guarantor Name (printed) Date