M.D.'s Weight & Wellness Center

200 River Pointe Dr. Suite 115 Conroe, Texas 77304
Phone: 936-756-8446 Fax: 936-756-8472

Financial Policy

YOUR RESPONSIBILITY
You are financially responsible for all services we provide for you.

PRIVATE INSURANCE PATIENTS
The M.D.'s Weight & Wellness Center does **not** accept assignment for insurances. You will be required to pay all applicable fees at the time of service. Our office will provide you with a detailed receipt with all the necessary coding in order for you to file for reimbursement with your insurance company.

METHODS OF PAYMENT
We accept cash, check, Visa, MasterCard and Discover. We do not accept post-dated checks, nor will we hold checks for any length of time. Payment arrangements may be made as necessary by calling (936)756-8446.

RETURNED CHECKS
There will be a $40.00 fee assessed for any and all checks returned from the bank for any reason.

MISSED APPOINTMENTS AND NO SHOWS
We see patients on an appointment basis and we request that you call in advance so we can reserve time for you. We make every effort to honor all time commitments and request that you extend the same courtesy to us by letting us know 24 hours in advance if you are unable to keep your appointment. **A fee of $25.00 will be added to your account, every time proper notice is not given.**

MINOR PATIENTS
For all services rendered to minor patients, the adult accompanying the patient is responsible for payment. Even if the parents are divorced the parent that accompanies the minor to the doctor is responsible for payment, regardless of the terms of the custodial agreement.

INFORMATION CHANGE
Please advise us of any address or phone number changes promptly.

COLLECTION PROCEDURES
Members of our billing department are always available to help you with questions and or payment arrangements. Once made in writing, agreements are binding. We consider payment by the patient for services rendered to be an important part of the patient's role in the patient/physician relationship. Failure to comply or respond to repeated communications from our office may result in discharge from the practice and/or involvement of an outside collection agency. All prior balances must be resolved before being seen by the physician.

I have read and understand the financial policy, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice. I hereby voluntarily consent to healthcare encompassing recommendations and treatment by my physicians, his/her associates, assistants or other healthcare providers, as may be necessary in my physician's judgment. I have relied on my physicians for information in this regard and acknowledge that no warranty or guarantee has been made as to result or care. This form has been fully explained to me, and I certify that I understand its contents.

_____ _____
Signature of Patient or Guardian if a Minor Date

_____
Please print patient name