RMC Rocha
MEDICAL CLINIC

3408 Roosevelt Avenue
San Antonio, TX 78214
P: 210.922.5922
F: 210.924.5600
rochamedicalclinic.com

Financial Policies and Procedures

- Please present your insurance cards each time to see our physician. It is your reponsibility to provide the correct information so that we can submit the medical claim with your insurance company.
- You also need to give us all changes in your address, telephone number and employer information, please give this information to our receptionist.
- We will need to collect your deductible, your co-pay or charges for the services not covered at the time of your visit. If there remains a balance after the payment by your insurance company, you will also need to pay this portion. We accept cash, Visa, Master Card or Discover.
- If we are not participating in your insurance plan, o the insurance company does not pay in time, or if your account is delinquent, we deserve the right to refer your account to a collection agency and to notify one or more credit bureaus of your credit.
- Medicare patients: we are providers under Medicare and we file charges to Medicare foll all covered charges. If you have co-insurance, this will also be filed. If you do not have co-insurance, you portion (20% of the approved amount by Medicare) will be colected at the time of your visit.
- HMO-PPO patients: If you participate with your plan, we will charge the insurance plan for your portion. The co-pay will be collected at the time of services without exeption. If you plan requires that you select a primary physician, you will be responsible to make sure that the doctor you see is on the list of participants. If your plan requires that you obtain authorization to see a specialist, you will have to obtain authrorization from our office before you see the specialist. We willl not be able to authorize retroactive visits. If the physician that you are seeing is not your primary care physician, we will not be able to authorize the visit with the specialist or the hospital.
- Priva pay patients: patients without health insurance coveragewill need to pay at the time services are provided. If you are not able to pay for the services the same day that they are proviced, you will need to communicate with our billing department before you see the physician and make arrangements for payment.
- Missed Appointments: your visit with the physician or provider is assigned a time allowance for you. When an appointment is not cancelled in advance, your time is not utilized; this is why we ask you to call us by phone to cancel your visit. If your appointment is not cancelled, you will be charged for the missed appointment. If you miss three appointments, you will be released from the practice for your lack of complying with agreed visits.
- Your insurance is a contract between you, your employer, and the insurance company. We are not part of this contract. It is very important that you understand the coverage and covered services under your policy. The reduction or refusal to pay claims by your insurance policy does not release you from your financial obligation with this office.
- Remember if you have or do not have health insurance, you are financially responsible for the payment of your charges. If you have any questions about our financial policies, please call our billing office at 210-922-5922.

Patient: Name: ____ Chart number: ___________________________

I agree to the following: I. Guarantee of payment: for the medical services provided to the patient whose name appears above. I / we, are responsible for paypment of the account of the patient based on the medical charges as published, that we are in agreement that these charges are just and reasonable. Also, if the physician does not ass for immediate payment, the payment due continues to remain the same.
When the payment from the insurance company is incomplete: whatever plan that the patient may have, such as but not limited to (Medicare, Aetna, BCBS, Medicaid, Humana, Cigna, worker's compensation) o any other coverage refuses to pay for the charges of the patient, or allows only part payment, we/I will be responsible for the immediate payment for the balance, as determined by the physician.

I have read and I am in agreement with the financial policies of Rocha Medical Clinic.

Signature: ____ Date: ______________________________________

Written Name: ____