



TEXAS A&M PHYSICIANS

Family Medicine & Residency
1301 Memorial Dr., Bryan, TX 77802
Ph. 979-776-8440/Fax 979-776-6905

Financial and Consent Agreement

ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

PATIENT INFORMATION FORM – FINANCIAL AGREEMENT

- 1) Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is received.
 - a) You are responsible for co-pays, deductibles, non-covered services, co-insurance and items considered “not medically necessary” by your insurance company.
 - b) For unpaid claims over 45 days, it is your responsibility to follow up with your insurance company and the balance due is considered due and payable.
- 2) It is your responsibility to notify our front desk or any insurance or address changes.
- 3) You will be responsible for any charges that occur if we are not notified.
- 4) Any debt incurred to collect a debt will be at the expense of the patient/responsible party.

PATIENT AUTHORIZATION & CONSENT

I, _____,(if minor, for _____ __ __) hereby voluntarily consent to medical treatment, including diagnostic procedures, surgical and other medical services, offered by the Texas A&M Health Science Center and its Clinics, physicians, nurses or their authorized designees, as they may in their professional judgment be necessary to provide appropriate medical, surgical or emergency care.

I authorize Dr _____ and/or Texas A&M Health Science Center to submit insurance claims using my signature on file below.

I authorize the release of any medical information necessary in order to process this assignment on the claim.

I authorize payment of medical benefits to be paid to Dr. _____ and/or Texas A&M Health Science Center for services described on the claim form.

PATIENT SIGNATURE (or authorized representative)

Date

PRINTED NAME (or authorized representative)

Date