HEALTH
FAMILY CARE

Psychiatry & Behavioral Health
2900 E. 29th Street, Suite 101
Bryan, TX 77802
Telephone: 979.774.8200
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 of 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 _____) here by 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 deem necessary to provide appr opriate 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**