Thomas A. Cadenhead, MD

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered a part of your treatment. The following is a statement of our financial policy which we require you to read, agree to and sign prior to any treatment.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE

We accept cash, checks, Visa, MasterCard, American Express or Discover.

REGARDING INSURANCE

We cannot bill your insurance company unless you give us your insurance information and your card to copy. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits, we require you to pay any deductible and/or co-pay due. If your insurance company has not paid your account in full within 45 days, the balance will automatically become your responsibility and payment will be due in full. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other medical insurances. Regarding insurance plans in which we are a participating provider, all co-pays and deductibles are due at the time of service.

I agree to pay for services rendered, unless other arrangements are made prior to my visit. Should my account become deliquent, I agree to pay necessary collection fees of 35% of the outstanding debt.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to the provisions of this financial policy.

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Signature of patient or person responsible for the bill Date

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address:

TEXAS STATE BOARD OF MEDICAL EXAMINERS
1812 Centre Creek Dr., Suite 300
P. O. Box 149134
Austin, Texas 78714-9134

Assistance in filing a complaint is available by calling the following number: 1-800-201-9353.