

**Dr. Rafael A. Rodriguez is pleased that you have selected our practice for you and/ or your family. In order to better serve your needs and avoid confusion, it is important for you to understand our financial policy.**

Dr. Rafael A. Rodriguez will process any and all insurance claims on behalf of our patients. Since it is impossible for us to keep track of every insurance plan and how it works, we expect you to know your plan coverage, (especially for supplies), co-pay and/or deductible levels. Dr. Rafael A. Rodriguez will assist you with your insurance coverage and paperwork to the best of our ability if you present your current insurance card or information at the time of service. Without current insurance information, you will be entered into our system as self-pay and will be required to pay at time-of-service (before treatment).

**Forms of Acceptable Payment:** Dr. Rafael A. Rodriguez accepts cash, checks or major credit cards. In the event that a check is returned as non-payable, Dr. Rafael A. Rodriguez may charge a service fee. In cases of dual custody, payment is required at the time-of-service regardless of who brings the child in for the appointment. If you do not have insurance, we will require payment at the time of service. You should contact our Business Office at (972) 216-5400 ext 101 to discuss payment arrangements if necessary.

**Copays/coinsurance/deductibles:** All co-pays/coinsurance/deductibles required by your insurance plan are collected at the time of service. Patients receiving services should be aware that although these services are medical in nature, they may be considered by your insurance company and therefore may require a separate copay or coinsurance.

**Referrals/pre-cert/prior auth:** If an insurance referral from your primary care physician is required, you must present it at the time of service. If you choose to be seen without the appropriate referral in hand, you agree to be responsible for the charges should they not be covered by your insurance. Patients are also responsible to do prior authorizations, pre-certifications, or to complete any other insurance requirements as necessary.

**Supplies:** In most cases we require payment for supplies when they are issued. We will submit all supply charges to your insurance company and will reimburse you should they pay, (e.g. Durable Medical Equipment, injections etc...). Supplies purchased will be accepted for return only according to the manufacturer's warranty. Dr. Rafael A. Rodriguez is NOT liable for any defects arising from the use or misuse of any manufactured products that it distributes and provides no warranty as to their performance or result.

**Disputes:** If for any reason you dispute coverage or payments made by your insurance company, it is your responsibility to contact the insurance company and to resolve the matter based on your insurance company's arbitration or resolution process. We will provide documentation (providing your signature of authorization is on file) to assist in the dispute resolution process. During this time you will be asked to pay in full the balance or schedule payment arrangements by contacting the Business Office at (972) 216-5400 ext 101.

**I understand and agree that regardless of my insurance, I am ultimately responsible for the balance of my account for any services rendered. I acknowledge that I have read and understand all of the foregoing and authorize Rafael A. Rodriguez, M.D. to treat me and/or my dependants.**

---

Signature

Date

**DR. RAFAEL A. RODRIGUEZ, M.D.**  
**INTERNAL MEDICINE**  
**3228 Interstate 30, Suite 200,**  
**Mesquite, Texas, 75150**  
**Specializing in Adults and Senior Citizens**  
**Ph# (972) 216-5400**

**Acknowledgement of Review of  
Notice of Privacy Practices**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I \_\_\_\_\_ give permission for Dr. Rodriguez and staff to speak to follow : \_\_\_\_\_ until otherwise notified by myself.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

