DeWitz Family Medicine PLLC

Heartfelt care for the whole family

150 Pine Forest Drive, Suite 403

Shenandoah, Texas 77384

Office: 936-271-0426 Fax: 936-273-0047

Financial Responsibility

General Information

We will need to scan your driver's license and insurance card so that it can be kept on file for future visits. If your insurance changes, you will need to let us know as soon as possible. We will contact your insurance company to find out your plan's benefits and your costs. If you contact your insurance company, and have a different understanding of your costs and benefits, let us know,

If you do not have insurance coverage, you will be responsible for your charges at the time of your visit. A $100.00 deposit is now required before your appointment. You may ask for a cash pay fee schedule, or discuss your needs with Dr.DeWitz.

We do not accept Workman's Compensation Claims. Most companies have a doctor or facility they want you to use for these needs.

Please read and initial the following important facts to indicate your agreement

- Dewitz Family Medicine PLLC may release any information concerning my condition, treatment or examination to third party payers as needed for payment purposes_______
- I authorize and request that my insurance company pay Dewitz Family Medicine PLLC for my care as my policy allows and provides_________________
- I will be responsible to pay my portion of deductibles, co-pays, or percentages as described in my policy at the time of my service_____________
- If the insurance I have on file does not pay for my services, I will be responsible for payment of these services._________
- I realize that insurance issues can be complex, and that I should contact my insurance company to be made fully aware of my benefits and responsibilities. _______________
- When I make an appointment, I am reasonably sure that I will be able to keep that appointment, and I will call at least 24 hours in advance to cancel it, if I am unable to keep it. If I do not cancel at least 24 hours in advance, I may be charged $25.00_____
- If my check is returned, I may be charged $25.00, or the amount allowed by law._________

Patient or representative____ Date__________________

If you have special financial needs, regarding your medical care, please discuss them with Dr. DeWitz..