DIAGNOSTIC PARTNERS OF NORTH TEXAS

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Murphy Medical Clinic, 345 West FM 544, Ste 100, Murphy
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PAYMENT CONSENT

Please be advised that we **no** longer **accept checks** as a form of payment. Your payment options that are accepted are: ***Cash, Visa or MasterCard***.

ALWAYS verify with front desk if you have a balance due. We will remind you before your appointment of any balance due. All outstanding balance must be cleared before seeing the doctor. If you are unable to clear your prior balance your appointment may be Re-scheduled until payment is made in full.

I _____ understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any diagnostic testing ordered by the physician. If some payment is requested on the date of service, I understand this is only an estimate of the patient responsibility and that I will be responsible for any additional charges that are not covered by my insurance once the claim has been processed. If I do not have insurance, I understand that I am responsible for all financial charges. I further understand that any payment that is returned (such as invalid credit card number or credit card fraud), will cause me to pay an additional fee of $35. I understand and agree that it is my responsibility and not the responsibility of the physician or his staff to know if my insurance will pay for my visit or diagnostic testing ordered by the physician or physician's staff. I understand and agree it is my responsibility to know if my insurance has any **Deductible, Co-payment, Co-insurance, Out of Network** amount, or any other type of benefit limitation for the services I receive.

Please indicate your form of payment for today's visit: **Cash** ☐ **MC** ☐ **Visa** ☐

Patient's Signature _____ Date _____

TESTING RESULTS CONSENT

Your health is very important to us. You will be informed as soon as we receive your final report from the lab or diagnostic facility if the results are **Normal or Abnormal** only. However, our office will **NOT** discuss your lab result over the telephone. If you don't hear from our office within 7 days after your testing, please call us to check your results. If any of your lab result is **abnormal**, you **must** make an appointment to see the doctor immediately in order to discuss your appropriate plan of care. It is imperative that you make an appointment within 1-2 weeks upon receiving the results. If your results are normal and there is no need to adjust your medication, then it is necessary that you comply with your routine check up every three months.

Patient's Signature _____ Date _____