



Patient Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_

**William A. Paruolo, M.D.,P.A.**  
**6053 Main Street Suite 225**  
**The Colony, TX 75056**

### **Financial Policy/Insurance Information**

We are committed to providing you with the best care, your clear understanding of our financial policy is important; in saying this if you have any questions regarding our fees, policy or your responsibilities regarding your account please contact us.

All Patients must have a complete and accurate **Patient Registration Form** on file with our office.

All Patients must present the patients current insurance card at time of service this includes Medicaid and CHIP patients.

**Payment:** Full payment for services is **DUE AT THE TIME THE SERVICE IS RENDERED**, when your child is accompanied by some one other than the parent then payment must accompany the child. We accept Cash, personal checks pre-printed with all current information on the front of the check, Visa, MasterCard and American Express. Returned Checks: There will be a \$30 return check fee for returned checks due to Non Sufficient Funds or Closed Accounts.

**We are not party to any legal agreements between divorced or separated parents. Whoever brings the child in for the appointment is responsible for payment at the time of service.**

**Your insurance policy is a contract between you and your insurance company.** Please read your benefits so you will understand what type of coverage you have. We cannot guarantee payment of your claims by your insurer. Rejection of all or a portion of your bill by your insurance company does not relieve you of the financial obligation that you have incurred.

**Cancellations and Missed Appointments:** We would like a 24 hour notice for all cancellations. If you do not show for an appointment there **may** be a \$25 fee for a missed appointment.

**Delinquent Accounts:** Should your account become delinquent for nonpayment you will be reported to our collection service; you may incur additional fees for collections. Accounts must be current before future appointments may be scheduled. If you are unable to make your payment in full please call our billing office at: 972-370-2425 to make satisfactory payment arrangements.

***I have read and understand the above policies and agree to accept responsibility for any financial obligations incurred.***

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

### **Insurance Information**

Name of Insurance \_\_\_\_\_ Group Number \_\_\_\_\_ Policy or Subscriber ID \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_ Phone \_\_\_\_\_

Policy Holders Address if different than Patients \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_