Family Medicine Associates of Round Rock, P.A.

7200 Wyoming Springs Rd., Suite 600 Round Rock, TX 78681 (512)-244-1995

Office Policy

Payment Policy
Payment for services is required at the time of service unless prior arrangements have been established. We accept payments via cash, personal checks, and major credit cards, including Visa, Mastercard, and Discover.
-To efficiently manage our billing costs, we kindly request that payments for office visits be made at the time services are rendered. We do not accept insurance forms as a substitute for payment; however, we will provide a receipt to facilitate the reimbursement process with your insurance carrier if we do not hold a current contract with them. Please retain your receipt, as there will be a fee for any duplicate copies requested.

Insurance Participation
We participate with several PPO and HMO insurance plans. If we are a provider within your insurance network, we will handle the claims submission on your behalf. Copayments are due prior to your appointment with the physician. You are responsible for any charges that are not covered by your plan. Should your insurance carrier fail to make payment within 60 days, you may be required to contact them for claim status. In the event that your claim is incorrectly processed, you may be billed for the outstanding balance.

Use of Artificial Intelligence in Healthcare
I acknowledge that treatment, procedures, and related functions at this practice may involve the use of artificial intelligence technologies designed to analyze large data sets to identify patterns and enhance service delivery. This use of artificial intelligence aims to improve the accuracy, reliability, efficiency, and safety of the services provided.

Texting Consent

☐ I consent to receive text messages from Family Medicine Associates of Round Rock using the phone number in my medical chart for communication regarding my healthcare. To opt out, text STOP. For assistance, text HELP or visit Fmarr.com. Message & data rates may apply. Messaging frequency may vary.

Phone #: _____

Consent for Telemedicine Treatment
I agree to receive medical care through electronic communication (Telemedicine). This allows healthcare providers in different locations to share my medical information for diagnosis, treatment, follow-up, and education. I acknowledge that while Telemedicine can improve access to care, there are risks involved, such as technical issues or equipment failures that might lead to lost information or delays in treatment. I know that I have the right to stop using Telemedicine at any time without affecting my future care or benefits.

Late Cancels/No Show Fees
Please be advised that a late cancellation is defined as any appointment canceled with less than 24 hours' notice or failure to show up, both of which will incur a no-show fee. Repeated no-show occurrences may result in the termination of your appointment privileges at our practice.

Authorization for Medical Information
By signing below, I authorize Family Medicine Associates of Round Rock, P.A. to disclose medical information related to my current illness or injury, including details pertaining to hepatitis and HIV, to any specialists or insurance companies as necessary for treatment. I further authorize the specialists and care providers to share relevant medical information with Family Medicine Associates of Round Rock, P.A. I consent to the faxing or emailing of this information where required.

Additionally, I authorize Family Medicine Associates of Round Rock, P.A. or their designated representatives to provide reasonable and appropriate medical care in accordance with contemporary standards. I also permit Family Medicine Associates of Round Rock, P.A. to share any acquired medical information with insurance companies or third-party payers for the purpose of securing payment for services rendered. If Family Medicine Associates of Round Rock, P.A. accepts assignment for my claim, I authorize the insurance company or third-party payer to remit payment directly to this office. I confirm that the insurance information provided is accurate, and I recognize that I am responsible for notifying Family Medicine Associates of Round Rock, P.A. regarding any changes to my insurance coverage. If I fail to do so, I understand I may be liable for all copayments, coinsurance, deductibles, and non-covered services, with payment due at the time of service.

I understand and agree to the Office Policy and that my signature and date on this form remain valid until I provide written notice of cancellation or once a minor reaches adulthood. I also acknowledge that a scanned or photocopied version of this document is considered as valid as the original.

Patient's Signature, Parent or Legal Guardian: _____ Date: _____

Printed Name: _____ DOB:_____

Relationship to Patient (if applicable): _____