Children's Medical Clinics of East Texas
1011 West Grove Street
Kaufman, Texas 75142
972-932-1319

PAYMENT POLICY

Thank you for choosing Children's Medical Clinics of East Texas. We are committed to improving and maintaining the health of the children residing in the communities we serve. In order to maintain this quality of care, Lone Star Pediatrics expects payment in full for all services. The parent/guardian of the patient is ultimately responsible for payment for these charges. As a courtesy, Lone Star Pediatrics will file a claim with the patient's insurance company if necessary information is provided. If payment is not received from the third party within 60 days from the date of service, the parent/guardian will be billed and held responsible for payment of the balance. The parent/guardian is also responsible for any charges that are not covered by the third-party payer: deductibles, co-payments and any other non-covered charges. These amounts are due at the time of service.

I hereby assign to Lone Star Pediatrics, any and all benefits and all interest and rights for services rendered under my insurance policies or any reimbursement or prepaid health care plan. I hereby promise to pay for all services rendered to me to the extent I am legally responsible for such payment. I understand I am responsible for all health insurance co-payments and deductibles at the time of service.

If I am a MEDICAID PATIENT, I understand that the services or items that I request to be provided to me may not be covered under the Texas Medical Assistance Program as being reasonably and medically necessary for my care. I understand that the Texas Department of Human Services or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services are determined not to be reasonable and medically necessary for my care. These amounts are due at the time of service.

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Parent/Guardian Signature **Date**

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Print Parent/Guardian Name

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Patient Name