

**PULMONARY SPECIALISTS OF TYLER, PA (PSOT) AND  
TYLER INPATIENT MANAGEMENT SPECIALISTS (TIMS)**

## Financial Policies

**Consent to Pay:** In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time the services are rendered. Our providers accept Medicare and many commercial insurance plans. Medicare will forward claims to most secondary payers. If we are contracted providers to your insurance plan, you will be required to pay your co-payment(s)/co-insurance and any unmet deductible at the time of service, as mandated by your insurance company. If we are not a contracted provider, you will be required to pay for your services at the time of service. It is your responsibility to verify with your insurance plan if we are a contracted provider. We accept Visa, MasterCard American Express, and Discover for your convenience. If you have a legitimate hardship, please ask to speak with a patient account representative so we may work with you. \_\_\_\_\_ (Initials)

I understand I will be responsible for any remaining balance not covered by my commercial insurance company, Medicare, and/or my supplemental policy. I authorize the transfer of credits from one entity to the other to satisfy any outstanding balances. I have read the financial policy and agree to meet my financial obligation in accordance with this policy. \_\_\_\_\_ (Initials)

Please be advised any outpatient procedures done where the doctor is involved in the actual test, will result in a statement being generated from the hospital as well as the physician's practice. \_\_\_\_\_ (Initials)

It is your responsibility to provide Pulmonary Specialists of Tyler, PA/Tyler Inpatient Management Specialists with current insurance information on each visit. Without insurance information, you will be responsible to pay for services at the time of the visit. \_\_\_\_\_ (Initials)

Please note that failure to cancel an appointment within 24 hours may result in a \$25.00 charge.

\_\_\_\_\_  
Patient/Guarantor Name (printed)

\_\_\_\_\_  
Patient/Guarantor Date of Birth

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Date