

David J. Lim, M.D., P.A
Diplomate, American Board of Urology
Fellow of the American Academy of Pediatrics
Adult & Pediatric Urology
T (713) 464-7643 / F (713) 464-3176

Financial Policy

We are dedicated to provide the best possible care for you. We want to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and understanding of our payment policy.

1. Our physicians participate in a number of HMO and PPO networks. **It is your responsibility to verify that the doctor you are seeing is in “network”.** Please verify this calling the “800” telephone number on your insurance card or check with your employer as to how to obtain this information.
2. If you belong to an insurance company that requires a referral from your primary care physician, **please bring the referral with you at the time of the appointment.** We must have a referral authorization before seeing you.
3. **Payment is due at the time of the service and co-pays and deductibles are collected before each visit.** If you are not insured by one of the participating HMO or PPO insurance companies, payment will be collected according to your plan’s out-of-network benefits. If you carry no medical coverage, payment in full is required at the time of your visit unless prior arrangement have been made. We accept **cash, checks, MasterCard and Visa.**
4. We accept Medicare assignment and will bill Medicare for you. If you have any supplemental insurance, please bring this information to your appointment. You may be responsible for a portion of your charges, as well as your **Medicare Deductible.**
5. **There will be a \$35.00 charge for all returned checks. We do not accept post-dated checks.**

We must emphasize that as healthcare providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I HAVE READ AND COMPLETELY UNDERSTAND THE FINANCIAL POLICY AND AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT SUCH TERMS MAY BE AMENDED BY THE PRACTICE FROM TIME TO TIME.

Signature of Patient (or responsible party, if minor)

Date

Please print the name of the patient