

**TexasMD Management Corp.**  
**Patient Billing Agreement**

1. I verify that I have updated TexasMD Management Corp. with my correct insurance information, and I agree to keep it current.
2. I understand that if my insurance claim is denied due to incorrect personal information or incorrect insurance information that I have provided, I will be billed and the payment in full will be due immediately.
3. I verify that I have designated Cyrus Peikari, M.D. of TexasMD Management Corp. as my primary care physician with my insurance plan. I understand that if my insurance company denies paying my claim for a visit because it is determined that Dr Peikari was not my designated PCP in effect at the time of my visit, that I am responsible for paying in full for all services rendered.
4. If I have insurance that TexasMD Management Corp. is contracted with, then I authorize assignment of payment directly to Dr. Peikari for services provided to me. I understand that TexasMD Management Corp. will file a claim with my insurance company, and that I am responsible for following up with my insurance company to insure my claim is paid within 60 days of my visit date.
5. I understand that if I have an insurance plan, and my insurance has not paid my claim within 60 days of my visit date, that the charges for the visit date will become my responsibility to pay.
6. I understand that, under the terms of the contract that I have with my insurance company, I must pay any pre-determined co-payments at every visit.
7. If I have insurance that TexasMD Management Corp. is not contracted with, I agree to pay my bill in full at the time services are provided, if requested. I understand that TexasMD Management Corp. will file a claim with my primary insurance carrier as a courtesy, but that it is my responsibility to follow up with my insurance company to insure reimbursement. I understand that I will be responsible for any balance remaining after insurance reimbursement. I understand that TexasMD Management Corp. cannot act as an intermediary between me and my insurance company to effect payment.
8. If I am a patient with no insurance coverage, I agree to pay my balance in full at the time services are rendered.
9. I hereby request and authorize TexasMD Management Corp. physician and personnel to deliver medical care to myself or my dependents.
10. I understand that medical records are the property of the physician of TexasMD Management Corp.; however, I am entitled to a copy, with sufficient advanced notice, upon my written request (patients aged 18 and older must sign their own medical record release form). I understand that there may be a charge for copies of my medical records.
11. I hereby authorize the release of medical information to my insurance company, Worker's Comp, etc. concerning any illness and treatment.
12. I acknowledge that I can obtain a copy of TexasMD Management Corp's Privacy Practices/Patient's Privacy Rights upon request.

I acknowledge the above by my signature below:

PATIENT/LEGAL GUARDIAN SIGNATURE \_\_\_\_\_

NAME: \_\_\_\_\_

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_