Charles A. Evans MD
203 Christie St.
Lufkin, TX 75904
936-699-5433
Fax: 936-699-5465

Billing and Payment Guide for Services Provided in Our Office

In order to provide you optimal healthcare Dr. Evans may feel it necessary to perform some testing. The majority of this testing will be performed and analyzed in this office by Dr. Evans. This guide is to help you understand the most common billing questions and what your personal financial responsibility may be.

Understanding Key Terms Concerning The Billing Process:

Copayment-the fixed amount a patient pays at the time of service' the amount varies depending on type of service
Deductible- the amount a patient owes for a covered healthcare service before the insurance begins to pay
Co-Insurance- the patient's share of the cost of a covered healthcare service, is usually a percent of the allowed amount for the service.
Explanation of Benefits- a notice from a Patient's insurance reflecting what was billed, what is allowable, what the insurance paid and what is due from the patient.

If your insurance sends you a check:

1. Endorse the check by signing the Back and writing "Payable to Dr. Evans" under your signature
2. Mail the check and EOB to:
   Dr. Charles Evans
   203 Christie Street
   Lufkin, TX 75904

Your Patient Financial Responsibility:

For Self-Pay Patients- Payment arrangements must be made in advance for all services
For in Network Services- the majority of patients have little or no responsibility other than their copay or once their deductible is met
Patient Assistance Program- patients who find it difficult to afford the testing recommended and/or required by Dr. Evans may apply for eligibility under the Medical Services Patient Assistance Program. Qualified applicants must attest in writing as to their household monthly income. A patient is eligible so long as their financial obligation is greater than 10% of the applicant's monthly household income. The following chart summarizes the obligation of eligible applicants.

Patient responsibility on outstanding balance	Patient responsibility prior to assistance discount
$50.00	Less than $250.00
$75.00	$250.00-$500.00
$100.00	$501.00 or more

Charles A. Evans MD
203 Christie St.
Lufkin, TX 75604
936-699-5433
Fax: 936-699-5465

Patient Assistance Form

Today's Date: _____/_____/_____

Patient Name: _____

I understand Dr. Evans has ordered diagnostic testing on me and that I am responsible for all or a portion of the cost of the services I am receiving. I acknowledge I have been given and reviewed the Billing and Payment Guide.

I attest my financial obligation for services poses a financial hardship for me or my family. Accordingly, it would be very difficult for me to afford the services recommended and/or required by Dr. Evans. As such, I am applying for eligibility under Dr. Evans Patient Assistance Program.

If my patient responsibility exceeds 10% of my yearly income, Dr. Evans will accept an amount not to exceed $100 from me, along with payment from my insurance carrier(if any), as payment in full.

If eligible I understand I may receive a bill for an amount up to $100.00. If I am ineligible I understand I will be contacted by a representative of Dr. Evans office to make payment arrangements.

I would like to pay $_____ today. For program eligibility purposes, I certify that my combined household monthly income is $_____.

_____ _____/_____/_____
(Patient Signature) (Patient Date of Birth)

_____
(Ordering Physician)

Method of Payment: ☐ Credit Card

☐ Check/Check #: _____