

TOWN & COUNTRY Family Physicians

Anthony J. Popek, MD Laurel M. Tucker, MD Henry C. Jackson, MD
Lubna Momin, NP-C Shannon Borden, NP-C

10497 Town and Country Way, Suite 360, Houston, TX 77024 Phone 713-341-2100 Fax 713-932-7072
www.townandcountryfamilyphysicians.com

To Our Patients:

Because of the increasing number of insurers that require “pre-authorization” for certain medications and the demands on our office staff, we must institute a new policy concerning pre-authorizations or substitutions for medications that our doctors prescribe.

When we prescribe a medication, we base the decision to prescribe on your medical needs and our experience with the medication. We do not prescribe medication based on whether your insurance prefers a certain medication.

If you want us to change a medication for reason of insurance coverage, please ask your doctor **at your next office visit.** and we will determine whether the change is appropriate for you. We will not be able to manage medication changes by telephone.

If you are prescribed a medication that your insurer will not cover, your options are to pay out of pocket or to see your doctor to discuss appropriate options.

You may FAX us a request to obtain pre-authorization. **If you have been prescribed a medication for which we must call for pre-authorization, there will be an administrative fee of \$25.00 to do so. This fee is not covered by your insurance and will be your responsibility to pre-pay for it. We cannot guarantee that your insurance will cover the medication, even if we request authorization.**

We regret that these changes have become necessary. Calls and letter to your insurer take time away from patient care and our nurses cannot attend to our patients needs if they are on hold waiting to speak to an insurance company. The task of doing your insurer’s work has become unmanageable. Your doctors cannot continue to absorb these costs.

I understand that is my financial responsibility if I request that my doctor’s staff contact my insurance company for administrative reasons on my behalf.

Print Patient’s Name Patient’s Signature Date _____ 20____

Credit Card#: _____ Exp. Date: _____ CVV# _____



please check what type of card: