

OFFICE AND FINANCIAL POLICIES

We would like to thank you for choosing North Texas Orthopedics & Sports Medicine (NTO) as your medical provider. To keep you informed of our current office and financial policies, we ask that you read, initial and sign our financial acknowledgement prior to any treatment.

Insurance: Please bring your insurance card with you at the time of your appointment. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. **The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier.** If you do not have your co-pay at the time of your visit, you must provide us a written waiver from your insurance carrier specifically authorizing NTO to waive this obligation.

Initials: _____

HMO or POS: For POS and HMO insurance plans that we participate in, your insurance carrier requires that you obtain a referral from your Primary Care Physician (PCP) before receiving services. Please bring that referral with you. Any services received without a referral or proper authorization will be your responsibility.

Initials: _____

No Insurance: Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our Billing Office Representative or Financial Coordinator.

Initials: _____

Auto Accident Injury: If your injury is due to an automobile accident, we request that you provide us with any information that will assist us in getting your medical claims paid. This information may include:

- a copy of the police report
- a copy of your auto insurance
- names and information on other parties involved

Payment for any services that we provide will be your responsibility.

Initials: _____

Canceled Appointments: If you are unable to keep your scheduled appointment, please call our office within 24 hours to reschedule your appointment, as this will enable us time to use your slot for another patient.

Initials: _____

Liability Injury: If your injury is a result from another party's negligence, we request that you provide us with any information that will assist us in obtaining reimbursement for the services rendered to you. This information may include:

- a copy of the accident report listing claim number and responsible part
- medical coverage and/or attorney information

Payment for any services that we provide will ultimately be your responsibility if not paid by promptly another party.

Initials: _____

Worker's Compensation: If your injury is due to an accident in your work place, please be sure to contact your employer and inform them of your injury. We will need to receive authorization from your employer before we can process any of your medical claims. Failure to properly report this injury to your employer may result in your claims being denied. Denied claims will be your responsibility.

Initials: _____

Return Checks: A \$35.00 charge will be added to your account for any check returned by your bank for any reason.

Initials: _____

Disability or Insurance Forms: There will be a charge of \$25.00 for the completion of medical forms. Pre-Payment is required prior to the form being completed. Please allow 5-7 business days for the completion of these forms. If you would like the forms mailed or faxed to you or your insurance company, please provide that request in writing at the time of payment.

Initials: _____

Medical Records: The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records. NTO charges \$25.00 for copies of your medical records, and a reasonable fee for the actual cost of mailing, shipping or delivery. Records are retained until payment is received.

Initials: _____

Diagnostic Imaging: For any, diagnostic imaging request, the fees are no more than \$10.00 per copy and reasonable fee for the actual cost of mailing, shipping or delivery. Films/disks are retained until payment is received.

Initials: _____

Fracture Care: Fracture Care is billed out as a "packaged" service which includes the following: Evaluation, the first cast or splint application, and 90 days of post-operative follow up care from the date of the fracture. There are some services that we bill separately which include: x-rays, all casting supplies, replacement cast applications, Durable Medical Equipment (DME), evaluations for any additional problems or injuries, and treatment of complications. Fracture care is listed as a "Surgical" procedure for billing purposes. This does not mean that we are implying that you will have an operation. This is how the CPT (Current Procedural Terminology) book organizes this service for ease of use by both the insurance companies and the physicians. Please note your insurance company may cover these services for fracture care differently than office visits. Therefore, your services may be paid as a surgical procedure, with deductible and coinsurance guidelines applied. If you have any questions or concerns, please contact our Billing office at 817-481-2121 opt 4.

Initials: _____

Minors: If the patient is a minor, he/she must be accompanied by Parent/Legal Guardian for each office visit. Minor Consent must be completed and signed by Parent/Legal Guardian.

Initials: _____

Disclosure of Ownership: Some of our physicians are invested in Ambulatory Surgery Centers like Baylor Surgicare at Bedford and Baylor Trophy Club. Their investment enables them to have a voice in the administration of policies of these facilities. This involvement helps to ensure the highest quality of surgical care for our patients.

Initials: _____

BILLING INFORMATION

As a courtesy to our patients we will file your insurance claims from our office. In order to do this we will require information from you. We ask that at the time of making your appointment, you inform the customer service representative of the type of insurance you have. Additional information will be required for those injuries or illnesses that are a result of a work or auto accident or if your case is under litigation.

We will need all your demographic and insurance information prior to your appointment. We ask that at the time of your appointment you bring your insurance card and a photo ID as well as any other information that will assist us in making sure that your claim is filed correctly.

At the time of service you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and non-covered services or items received. For your convenience we accept cash, checks, credit cards (Visa, MasterCard and Discover), American Express, Care Credit and money orders.

Although we are contracted with several insurance companies, it is your responsibility to make sure that our physician is in your plan. Also, if your insurance requires a referral for any services or products, it is your responsibility to obtain the correct referral for those services. It is your responsibility to know your insurance.

Although we will file your insurance forms, payment for your medical services is your responsibility. We will assist you in any way we can to help make this process as smooth as possible. We offer as a courtesy verification of your insurance benefits, however; this is only a quote given by your insurance company. Information may vary from the verification obtained to the actual processing of your claim. It is your responsibility to know your plan benefits.

I acknowledge financial responsibility for services rendered by North Texas Orthopedics & Sports Medicine. I understand that I am responsible for prompt payment of any portion of the charges including deductibles, co-pays and co-insurance. My signature authorizes NTO to file claims for me and assigns all medical rights and benefits due for these services.

Signed _____ Date _____

Printed Signature _____