OFFICE POLICIES AND FINANCIAL RESPONSIBILITIES

Please initial ALL SPACES below, acknowledging that you have read the Financial Policies even though all aspects may not apply to you.

We would like to thank you for choosing North Texas Orthopedics 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 North Texas Orthopedics to waive this obligation.

Initials: __________

**HMO or POS:** For the 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 of 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 of 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 the claim number and responsible party
- 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: __________
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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 $15.00 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. North Texas Orthopedics charges up to $25.00 for copies of your medical records and charges 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 doctors.

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 option 4.

Initials: ______________

Minors: If the patient is a minor, he/she must be accompanied by a parent/legal guardian for each office visit. Minor consent must be completed and signed by a 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 automobile accidents 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, coinsurance, deductibles and noncovered 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 doctor 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. As a courtesy, we offer 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. I understand that I am responsible for prompt payment of any portion of the charges including deductibles, co-pays, and coinsurance. My signature authorizes North Texas Orthopedics to file claims for me and assigns all medical rights and benefits due for these services.

Signed: ___________________________ Date: ___________________________

Printed Signature: ___________________________