Center for Orthopaedic Surgery and Sports Medicine
7940 FLOYD CURL DRIVE SUITE 560 • SAN ANTONIO, TX 78229
PHONE: (210) 692-7400 • FAX: (210) 692-0090

Patient Financial Policy

Thank you for choosing us as your health care provider. We are dedicated to providing our patients with a high standard of care for your othopaedic and sports medicine needs. Throughout the medical field today, fee reimbursement continues to decline while our costs continue to increase. We have implemented this Patient Financial Policy in an effort to control our costs while providing high quality medical care to our patients. Payment at the time of service is required for office visits and x-rays. We accept cash, checks (with the appropriate identification), most major debit and credit cards as well as care credit. Our staff will provide you with the appropriate receipt for you to file with your insurance company. For surgical procedures, please be aware that we collect an estimated amount for the Surgeon's fee and payment is due 48 hours prior to the procedure. Should your insurance company pay these procedures in full and we have received confirmation, we will apply any overages to outstanding balances and then refund the remaining amount. Refund checks will be mailed to the address on file.

Preferred Provider Insurance (PPO)

We are happy to assist you by billing your insurance company for all for office visits and surgical procedures and requesting the insurance company to remit payments directly to this office. Of course, you are responsible for any deductible and any co-pay your insurance requires at the time of service, as well as any difference between the amount of our fee and the amount received from your insurance company.

HMO/POS (Point of Service)

As a courtesy to our patients, we require referrals/authorizations prior to your visit. It is the patient's responsibility to provide us with the authorization from the referring physician. Without this authorization, your insurance company may not pay for treatment, and, of course, you would therefore responsible for payments of all charges. With the appropriate forms, we will bill the insurance company for all charges with the exception of any deductible or co-pay requirements.

Medicare

We participate in the Medicare program and fully cooperate with all of their rules and regulations. However, you are responsible for any deductible and co-pay requirements at the time of service. As a courtesy to our patients, this office will file for secondary insurance. If payment is not received within 30 days from the time of filing, the balance will be the responsibility of the patient.

It is the responsibility of all patients to provide this office with their most current information, to include insurance cards and any changes in coverage or status. It is also the patient's responsibility to provide this office with all appropriate forms necessary at the time of treatment. We encourage patients to understand their plan and contact their insurance company for clarification. Please check your plan to see if our physicians are providers within your insurance company's network.

I have read the Patient Financial Policy and agree to abide by its terms, as well as authorize my insurance company to forward the Explanation of Benefits and related payments directly to the physician's office.

Patients Name: ____ Date: ______________________

Patient, Parent or Guardian Signature: ____

Please note you may be referred for imaging services or to an ambulatory surgery center where one or more of the practice physicians may have a financial interest, whether ownership or compensation, including, but not limited to Sendero Imaging and CHRISTUS Santa Rosa Physicians Ambulatory Surgery Center.

TURN PAGE OVER

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ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort fees or insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Name:____ Date: ____________________

Patient, Parent or Guardian Signature: ____