Financial Policy

Patient Name: _____ Date of Birth: _____

Thank you for choosing **Advanced Surgical of North Texas**! We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship.

We sincerely hope that by sharing our financial expectations we will strengthen the physician patient relationship and keep the lines of communication open. This financial policy helps us provide quality care to our valued patients. If you have any questions or need clarification of any of the below policies, please feel free to contact our billing department at 972-439-3753.

Payment is Due at the Time of Service

_____ All co-payments, deductibles, co-insurance and fees for non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment.

_____ Insurance required co-payments are due when you check in for your appointment. If you arrive without your co-payment, we may ask you to reschedule.

_____ Patient-responsible balances are due when you check in for your appointment.

_____ In the event you need surgery there is a $200 surgery deposit fee due at the time surgery is scheduled. We will provide you an estimate of your insurance deductible and co-insurance amounts which is required to be paid before surgery is scheduled. The deposit fee will apply towards this balance.

_____ We request that at least 24-hour notice be given to the office if you will be unable to keep your scheduled appointment. A $25 fee will be assessed for no shows and/or failure to give proper notice.

_____ We require a seven day notice if you are unable to keep your surgery appointment.

Proof of Insurance

- Please bring your insurance card(s) and a valid photo ID with you to each appointment.
- It is your responsibility to notify the Practice of changes in your health insurance.

Referrals

If you have an HMO plan we are contracted with, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, call your primary care physician to obtain it. Without an insurance required referral, the insurance company will deny payment for services. As such, if you are unable to obtain the referral at that time, we will have to reschedule or ask to pay for the visit in advance.

Billing, Payments and Refunds

If we must send you a statement, the balance is due in full within 14 days of the statement date.

- If you cannot pay the balance in full within 14 days, please contact our billing department to see if you qualify for special payment options.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.
- We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take

other collection action or end the physician-patient relationship.

FMLA and Disability Paperwork

- If you require FMLA or Disability Forms please bring these before your scheduled surgery. A separate form will need to be completed for authorization and explaining the process. There is a minimum turnaround time of 7-10 business days.
- There is a minimum $15 charge for completion of these forms.

Physician Surgery Assistant

- Physician Assistants serve a vital role in the treatment of our patients. They perform a wide spectrum of duties such as patient management and surgical assistance. Our practice employs PA's to perform levels of care that is approved by the Texas State Medical Board. You may be seen and treated by a physician assistant that is acting under our supervision.
- A Physician Assistant is present for all surgical cases. We will bill your insurance company for these services. I understand that any charges denied by the insurance company may be my responsibility for payment.
- I have read the above, and consent to the services of a physician assistant for my healthcare needs.
- I understand that at any time I can refuse to see the physician assistant and request to see a physician.

_____ I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance company as well as applicable copayments and deductibles, are my responsibility.

_____ I authorize my insurance benefits be paid directly to Advanced Surgical of North Texas. In the event my claim is denied, I authorize Advanced Surgical of North Texas to file an appeal on my behalf.

_____ In order to properly treat me, I authorize Advanced Surgical of North Texas permission to view my prescription medication records.

_____ I authorize Advanced Surgical of North Texas, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures.

_____ I authorize Advanced Surgical of North Texas to release to appropriate agencies, any information acquired during my or the above-named patient's examination and treatment.

_____ I authorize Advanced Surgical of North Texas to contact, discuss my personal health information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

With my consent (Please initial one):

_____ Advanced Surgical of North Texas may call and leave a voicemail, speak to family/household answering my phone, send mail or email about any items that assist the practice in carrying out treatment, payment or operations such as appointment reminders, billing information,

insurance items and any call pertaining to my clinical care, including laboratory results.

_____ I direct that no voicemail messages may be left on my phone or speak to anyone in my household other than myself.

_____ I agree to accept paperless statements which will be sent to the email address on file.

Acknowledgement of Advanced Surgical of North Texas Notice of Privacy Practices

I have reviewed this office's notice of privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Guarantor

_____ _____

Patient Signature Date