

Orthopaedic Associates of North Texas

Clinic Financial, Appointment & Privacy Policies

FINANCIAL RESPONSIBILITY AGREEMENT:

I agree to assign insurance benefits to the Orthopaedic Associates of North Texas. We bill all insurance companies that we are contracted with as “network” providers as a courtesy to our patients. If you have two insurance plans, we also bill the secondary plan.

I understand that my personal payment (copayment, deductible and/or coinsurance) is required at the time services are received. Payment can be made in cash, personal check (in-state) or by credit card (Visa, MasterCard, Discover or American Express). We will estimate your total payment responsibility prior to your medical appointment. This amount includes copayments, deductibles, coinsurance and items not covered by your insurance plan. We will bill you any remaining balance based on your insurance plan’s Explanation of Benefits (EOB), which is also mailed to you. Overpayments will be refunded to you immediately.

Please visit with or call our Collections Office (972-727-9995) if you are ever unable to pay the amount due when billed. We offer payment plans to our patients. If your account is ever sent to our collection agency, you are responsible for the outstanding balance and the fee charged by the agency. Again, please call us if you cannot make a payment. We try our best to work with each patient.

PRIVACY PRACTICES:

We are committed to ensuring your Protected Health Information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent or to your insurance carrier, other medical professionals directly involved with your care, or as required by law. Our “Notice of Privacy Practices” policy manual, which explains how your medical information may be used and disclosed, is available for your review or you are welcome to have a copy.

GENERAL RELEASE OF INFORMATION:

I authorize Orthopaedic Associates of North Texas to release information regarding my care to my insurance company, pharmacist and to any physician involved with my care. I understand that I may withdraw this consent at any time.

MISSED APPOINTMENTS:

If you cannot make your appointment, please call us immediately so that we can offer that appointment to another patient.

CONSENT OF TREATMENT:

I authorize Orthopaedic Associates of North Texas to evaluate and treat me or my family member for any orthopaedic illness or injury for which I seek medical care.

I read and understand the above clinic policies.

Patient or Guardian Signature

Date