GENESIS
ORTHOPEDICS
& SPORTS MEDICINE

Hythem P. Shadid, M.D.

STATEMENT OF FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the success of your treatment and care. The following is our statement of Financial Policy, which we ask all of our patients to read, understand, and sign prior to any non-emergency treatment or care.

We will be happy to bill your insurance company, but we need complete information including a copy of your insurance card. Please give that information to our front desk staff.

Methods of Payment:
We accept Cash, Checks, Visa and Master Card. We offer payment plans and are happy to provide financial counsel, if requested.

About Your Insurance Coverage:

- Commercial/Indemnity Insurance: Your policy is a contract between you and your insurance company. Since we are not a party to that contract, your account balance is your responsibility whether your insurance pays or not. As a courtesy, we will file a claim on your behalf. However, if your insurance does not pay within 60 days, you will be responsible to pay the balance of unpaid charges and follow-up with your insurance directly.
- Managed Care Plan (HMO, POS, PPO): You will need to pay any co-payments, deductibles, and non-covered services at the time services are rendered. It is the patient's responsibility to verify a physician's participation in their health plan prior to making an appointment. If your plan requires a referral for ANY service beyond your Primary Care Physicians' office, you need to contact the Referral Coordinator at your Primary Care Physician's office. This will allow you to obtain the necessary information and authorization for your visit. Please understand that if you fail to do so, the visit may NOT be authorized by your insurance carrier. We need to comply with your insurance company's rules as retroactive referrals for services already provided, will NOT be issued.
- Medicare/Medicaid: We are required to file claims with Medicare and/or Medicaid. You are responsible for all Medicare co-payments and for services not covered under the Medicare program. If you are covered by Medicaid, you are responsible for providing proof of **current** coverage and any applicable spend-down amount.
- Self-Pay or Self-Filing: Patients who do not have insurance coverage, who have insurance coverage but are unable to provide us with valid insurance information, or who wish to file their own insurance claims, are responsible to pay 100% of charges at the time services are rendered. If you cannot do that, please discuss that with our staff.

When is Payment Due?:
Payment is due at the time services are rendered in the office. To see how this affects your specific insurance situation, please discuss with the registration staff.

About our Staff:
Our staff understands many insurance company policies, but they DO NOT have all the answers about your specific benefits. Your employer should have a copy of your *Benefits Guidebook*, or call your insurance company, should you need detailed information about your coverage.

Past Due Account Balances:
If your account balance becomes past due, appropriate action will be taken to collect the amount due. If you have issues that prevent you from paying the full balance due, please contact our office so we can help find a solution. If your account is in Collection, you may be dismissed from our practice and no longer eligible for services until your balance is paid in full.

Please Turn to the Reverse Side

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www.genesisortho.com

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Returned Checks:
The fee for all checks returned for insufficient funds is $20.00. This fee will be automatically charged to your account when your check is returned from the bank.

CONSENT FOR TREATMENT
I acknowledge and understand that, in presenting myself for treatment and continuing medical care at Genesis Orthopedics & Sports Medicine, that I authorize to the administration and performance of all tests and treatments, which may be ordered by the physician (and/or designated assistant) and carried out by members of the Genesis Orthopedics & Sports Medicine staff and personnel.

Unaccompanied minors may need to be accompanied by a parent/legal guardian for routine care according to office policy.

ASSIGNMENT OF BENEFITS
In consideration of these medical services, I hereby assign, transfer and set over to Genesis Orthopedics & Sports Medicine, all my rights, title and interest to medical reimbursement benefits under my insurance policy(s) as indicated below. If my insurance benefits are provided through an ERISA plan (Employment Retirement Income Security Act), I hereby assign, transfer, and set over all my rights, title and interest as beneficiary of the ERISA plan to Genesis Orthopedics & Sports Medicine, with regard to my treatment and care with this practice.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with the opportunity to review the Genesis Orthopedics & Sports Medicine Privacy Notice during this visit/prior visit. I understand that I may obtain a copy of the original document and any future revised Notices at this office or on the practice website which can be found at www.genesisortho.com.

____ ________________
Patient//Legal Guardian **Date**

Reason that Notice was not accepted or patient/representative did not acknowledge receipt:
__ Patient indicates received on prior visit ___Patient declined to sign __ Other ____________________
__ Patient/Representative initials if declined ___ Employee Initials (if patient/representative did **not accept**)

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR PAYMENT
I authorize Genesis Orthopedics & Sports Medicine to release medical information or copies from my medical record within a reasonable time frame to insurance companies, third party payors, or authorized agents; or claims review organizations in order to process a claim for payment on my behalf. This information may be disseminated to any and all employers insurance companies or their designees who may provide coverage for medical charges and to comply with the requirements of any Professional Review Organization. This authorization may be revoked in writing at any time.

Thank you for reading and understanding our Statement of Financial Policy. Please let us know if you have any questions or concerns.

I HAVE READ THE STATEMENT OF FINANCIAL POLICY AND AGREE TO THE POLICY

____ ________________
Print Patient's Name **Date**

____ ________________
Signature of Patient or Guarantor **Date**