



Welcome,

Thank you for choosing our practice for your orthopaedic healthcare needs. On behalf of everyone at Advanced Orthopaedics & Sports Medicine (“AOSM”), we welcome you to our practice.

We strive to offer comprehensive, quality care to all of our patients. We feel that it is appropriate to inform our patients of our financial policies and procedures, and of any authorization requirement we need that may ultimately affect your care. The policies and procedures are available at your request or may be viewed on our webpage at:
<http://www.advancedosm.com/>

If you have any questions about these policies and procedures, please ask one of our staff members for help.

Thank you again for choosing Advanced Orthopaedics & Sports Medicine.

Sincerely,

The physicians and staff of Advanced Orthopaedics & Sports Medicine



Welcome to Advanced Orthopaedics & Sports Medicine

Financial Policies and Procedures

Payment Methods

I am responsible, at the time of service, for all expenses incurred during my office visit. AOSM accepts payment by check and credit card (Visa, Discover, American Express and MasterCard). AOSM will assist me in paying owed amounts through the option of a payment plan with monthly automatic withdrawal of an agreed upon amount in writing from a checking account or credit card account over a period not to exceed six months. All delinquent payments are handled in accordance with applicable banking laws and regulations.

Uninsured Accounts

AOSM will offer me a discount (time of service payment discount) should I not have insurance or should I specifically elect to not use my insurance for payment. The amount I will pay is determined from a defined fee schedule and considered payment in full. I understand that the time of service discount applies to all patients for services provided. I understand that AOSM has agreed to furnish the healthcare services I have requested or for which may be recommended by a healthcare provider of AOSM in exchange for payment in full from me at the time of service. The at time of service discount is offered to me because I do not have insurance available to pay for all or a part of the service to be furnished by AOSM and I have agreed to pay in full for services at the time of service. I further acknowledge and attest that I do not have insurance coverage for this service or have made the sole and personal decision to not use my insurance coverage and will in no way file a claim for this service with any insurance carrier at any point in the future.

Financial Responsibility Resulting from Insurance

I understand that I am responsible for my cost sharing as defined by my insurance carrier at the time of service. AOSM will submit claims to my insurance carrier for primary and secondary insurance covered services. AOSM will prepare a statement on amount owed if amount was unable to be calculated at the time of service. Payment or payment arrangements will be made by me within thirty (30) days of a receipt of a statement by AOSM.

Insurance Policy Provision

I understand for purposes of this document that "insurance carrier" shall mean a health plan or insurance company and benefit plans offered by similar organizations or other types of benefit plan structures. "Insurance carrier" shall include programs offered by The Centers for Medicare and Medicaid Services, related Medicare replacement plans, secondary insurance plans, related Medicaid replacement plans, programs offered by the Department of Defense and all organizations offering a form of health care or medical benefit coverage.

AOSM may or may not participate with my insurance carrier. It is my responsibility to determine the financial obligations of care. My insurance policy is a contract between me and the insurance carrier. I am ultimately responsible for all charges incurred at AOSM. It is my responsibility to know the benefits and provisions of my insurance policy. If I have any questions or concerns regarding the benefits of my policy, I will contact my insurance company directly. I am responsible for all charges denied or reduced by my insurance carrier. A current insurance identification card is required at each visit. If my insurance cannot be verified at the time of my visit, I will be obligated to pay for services until confirmation of my insurance coverage can be obtained. I shall supply current and accurate information regarding my insurance policy.

Referrals, Pre-Certifications and Authorizations

I understand that my insurance carrier may require I have a referral to be seen, that pre-certifications to receive services or authorizations may be required and that I shall be solely responsible to obtain required approvals and referrals to receive care. I understand that if I do not have or obtain necessary referrals, authorizations or fail to notify immediately my insurance company of any hospital admissions or non-routine care may result in me being responsible for payment for those services.

Healthcare Provider Classification

AOSM is recognized as a specialist care provider. AOSM may or may not be a participating provider with your insurance carrier.

Non-Covered Services

Non-Covered services as defined by my insurance carrier will be required to be paid for at the time of service. Possible examples of non-covered services include certain injections or durable medical equipment. Non-Covered services could



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include also services previously covered by my insurance carrier but are services that have a limitation on coverage making a covered service a non-covered service. The determination of coverage is defined by your insurance carrier and subject to your certificate of coverage and policy with the insurance carrier you have selected to assist in your obligation of payment for services. I understand that it is my responsibility to contact my insurance carrier regarding my specific plan structure and coverage.

Diagnostic and Laboratory Testing

My care at AOSM may include laboratory and diagnostic testing. Tests performed and billed by AOSM include but are not limited to certain pathology and radiology testing. All other testing not performed and billed by AOSM are performed by outside vendors. I will receive a separate billing for these services from that vendor (laboratory or diagnostic testing center). For laboratory, specimen handling fees will be charged by AOSM. If my insurance carrier requires use of a specific laboratory or diagnostic testing center, I will inform the provider and practice at time testing is ordered. AOSM will not be responsible for specimens sent to the wrong laboratory or referrals to testing centers. I understand that there may be many different laboratory and diagnostic testing or screenings that AOSM healthcare providers feel are required for my medical care which may not be covered by my insurance carrier (non-covered services). The healthcare providers have no knowledge of my insurance benefit plan so there is no guarantee that any test ordered will be covered by my insurance carrier. In many cases patients request these non-covered tests. The testing centers will submit charges for these tests and I am ultimately responsible for payment of such testing. As an informed consumer and active participant in my healthcare, I will make sure that I understand exactly what test are being ordered by my healthcare provider before permitting the tests to be performed.

Collection Activities

Returned Check Fees

I understand that if AOSM receives a returned check written by me or on my behalf, I will be charged a returned check fee of \$30.00 and will be required to pay cash or use a credit card for any future payments for a defined period of time. Failure to repay the returned check and the returned check fee may result in collection proceedings and may lead to dismissal of me as a patient from AOSM.

Account Interest

I understand that my account balance must be paid within 30 days but not later than 90 days after I receive a statement reflecting my account balance. Account interest will be calculated each month on the amount of the unpaid balance (referred to as Previous Balance) after deducting payments or adjustments and before adding new services. After 90 days, I will be charged at a rate of 18% per annum and charged on a monthly basis thereafter until the balance is paid in full. Account Interest is only applied to amounts I may owe and not owed on my behalf by my insurance carrier.

Collection Process

Any balances determined as patient responsibility that remain unpaid after 90 days will be subject to an in house review. If at that time satisfactory payment arrangements have not been established, I understand that I will receive a letter from AOSM notifying me that I have until the end of the current month or date noted in the letter to pay my balance in full or my account will be forwarded to an outside collection agency and I will be subject to an additional processing fee of \$25.00 in addition to any Account Interest. I further understand that I may not be allowed to schedule any further appointments with AOSM, receive any medication refills, or seek any medical advice of any kind from AOSM until this collection balance is paid in full except if I am hospitalized or in a limited post-operative follow-up period. In the event my account is sent to an outside collection agency, I understand that I will be obligated to pay collection company fees. I too shall be reasonable for attorney fees and court costs should the collection proceedings advance to litigation.

Service Fees

The following are some but not all service fees assessed by the practice. Service fees are subject to change at the discretion of the practice.

Medical Records Releases

AOSM will only release medical records when a valid, HIPAA compliant authorization or a court-ordered subpoena is



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received. Due to increasing costs of office supplies, equipment and postage, AOSM will assess appropriate fees for the copying and mailing of medical records. Please contact the AOSM Medical Records Department for further information regarding any specific request for copies of medical records.

Missed Appointments

I understand that AOSM may, but is not required to, call me to confirm my upcoming appointment date and time. I understand that this is a courtesy and that I am ultimately responsible to keep my office appointment. I understand that AOSM may charge a \$25.00 missed appointment fee and that I will personally pay the fee for appointments missed and not changed or cancelled within 12 hours prior to my scheduled appointment.

After Hours Phone Calls

Healthcare providers should only be called or paged after normal business hours for serious health concerns. In the event of a true emergency, I should call 911 or go to my nearest emergency room. AOSM normal business hours are posted in the practice and subject to change. Patients are directed to call their pharmacy directly during the day for prescription refills for prompt service. The pharmacy will then call our office for renewals if necessary. AOSM will not refill prescriptions after normal business hours. Calls that result in consultation to an established patient, parent, or guardian not originating from a related service within the previous seven days and not leading to a service or procedure within twenty-four hours following the telephone call will be charged.

Disability, Insurance or Employment Forms

AOSM will prepare necessary forms supplied by the patient that are required by insurance companies or employers. These forms are often quite detailed and lengthy and therefore cannot be completed quickly. AOSM requests that the patient leave the form at our office for completion with all information that you can provide all ready filled in. AOSM staff will then complete the form within ten (10) working days. AOSM may charge a usual and customary fee for each form completed. Payment in full is required at time of request to complete forms but not later than the time at which such form are released.

Economic Hardship

AOSM maintains an economic hardship policy for patients unable to meet the financial obligations of services rendered. The policy allows AOSM to write down the balance owed when income levels do not meet a threshold calculated as a percentage of the federal poverty level. Patients may qualify for such discount once per year when meeting the written definition maintained by the Business Office of an economic hardship discount. The classification of economic hardship requires documented proof from the patient in accordance with written guidelines that may include disclosure of IRS annual tax filing returns to the Business Office.

Out-of-Network

In cases where AOSM is not recognized as a participating provider and considered "out-of-network", AOSM may elect to notify and provide full disclosure upon submission of a claim to my insurance carrier that AOSM will offer a discount to me as their insured member. AOSM will bill my insurance carrier its full charge and then discount the patient portion of the payment to usual and customary as defined by my insurance carrier. Should my insurance carrier offer payment to AOSM at the discounted rate offered to me as the patient, AOSM will accept the payment from the insurer as payment in full. AOSM at no time is charging two different prices for the same service nor is pricing based on the fact that an insurance company may be paying for all or a part of the service rendered. This is not a waiver or discount of any co-payment, coinsurance or deductible amounts owed for services rendered and is not offered and should not be interpreted as an "inducement" to have services rendered.

Final Costs of Services

I understand that I may inquire about costs of services for office, laboratory, surgical or other procedures. I also understand that AOSM representatives can only estimate potential costs and cannot guarantee my final costs until all procedures have been performed and documentation has been reviewed by AOSM business office. I further understand that after review of my procedures I may receive a statement for additional expenses. The practice will comply with requests for estimate of charges and will supply that to me before the 10th business day after the date on which the estimate is requested.



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Discharge of a Patient

I understand that AOSM has the right to discharge any patient from this practice at anytime for various reasons, including but not limited to, failure to abide by AOSM financial policies, noncompliance of recommended treatment plans, drug-seeking activity, and any abuse of AOSM health providers and staff. If this occurs, I understand that my medical records will be released to a physician or healthcare facility of my choice only after an appropriately signed documentation is received by AOSM. I further understand that once discharged from AOSM, I will not be allowed to return as a patient of AOSM in the future.

Authorizations

Assignment of Benefits

I certify that the information I have given to AOSM is true and correct to the best of my knowledge. I promise to pay to AOSM all charges and expenses for services provided to me by AOSM in accordance with its current fees and charges to the extent that those fees and charges are not covered or paid by my insurance or by another payment source such as Medicare or Medicaid. I request that payment of authorized benefits under any private or government insurance program that covers me, including the Medicare program, be made on my behalf to AOSM for any services furnished to me by AOSM. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine my Medicare benefits, if any, for services furnished by AOSM. I understand that possession of medical insurance does not relieve me of financial responsibility to AOSM. I will personally be responsible for all charges for services that are not covered by my insurance carrier.

Record Usage

I give my consent for AOSM, its staff and business associates to use my medical record for data gathering and research purposes. I understand that ALL identifying information in my record will be coded for confidentiality. I understand that all patient and medical provider communication is and will be held in the strictest confidence.

Consent for Medical Treatment

I consent to treatment as deemed necessary and appropriate by clinical providers of AOSM.

Consent for Use and Disclosure of Health Information for Treatment, Payment and Operations

I consent to the use and disclosure of my protected health information by AOSM, its staff and business associates for the purposes of treatment, payment and health care operations. My protected health information includes any information that reasonably identifies me and relates (1) to the provision of healthcare to me, (2) to any of my past, present or future health conditions, or (3) to the past, present or future payment for any provision of healthcare to me. The information that is protected includes information related to my physical or mental health. I understand that I have the right to request that the practice restrict its uses and disclosures of my protected health information that the practice is otherwise permitted to make for treatment, payment and health care operations. AOSM, however, is not required to agree to these restrictions. Nevertheless, if AOSM agrees to any restrictions, those restrictions are binding on it. Finally, I understand that I have the right to revoke this consent in writing, except to the extent that AOSM has acted in reliance on it.

Appointed Representative

AOSM may pursue collection of benefits in my name or in the name of AOSM as my appointed representative and agent.

Notice of Privacy Practice

I acknowledge that I have been given a copy of AOSM practices Notice of Privacy Practices.

Rest of Page Intentionally Left Blank



I have read and understand the financial policies, procedures and authorizations of Advanced Orthopaedics & Sports Medicine to include payment methods, uninsured accounts, financial responsibility resulting from insurance, insurance policy provisions, diagnostic and laboratory testing, collection activities, service fees, economic hardship, out-of-network, final cost of services, discharge of patient, and authorizations to include assignment of benefits, record usage provision, consent for medical treatment, consent to use and disclosure of health information for treatment, payment and operations, appointed representative and notice of privacy practices.

I understand that these policies, procedures and authorizations outlined in the Financial Policies and Procedures may be amended from time to time at the discretion of the practice and apply to me. I authorize the use of a copy of this authorization in place of the original.

Please print patient name: _____

Patient Signature: _____ Date: _____

Date of Birth : _____

If patient is a minor (less than 18 years of age) or incapacitated:

Please print responsibility party name: _____

Responsible Party Signature: _____ Date: _____

Relationship to Patient: _____

Economic Hardship Documentation

Patient's Name:	Date of Birth:
Address:	Apartment:
_____ Rent (_____ monthly Rent) _____ Own (_____ mortgage amount)	

Family Information			
Number of family members living in household: _____			
Name	Relationship	Age	Gender

Family Income	
	<u>Gross Income per Month</u>
Wages Self:	_____
Wages Spouse:	_____
Wages Other family members:	_____
Government Assistance:	_____
Alimony:	_____
Child Support:	_____
Other income:	_____
TOTAL INCOME:	_____

- I declare under penalty of perjury that answers given are true and correct to the best of my/our knowledge.
- I agree to tell the provider of services, monthly, if there is any change to my/our income, or # of persons in the Household.
- I agree that in consideration for receiving health care services as a result of an accident or injury, to reimburse provider from proceeds of any litigation or settlement resulting from such act.
- I understand that my Charity status is valid at this specific location only.
- I understand that if I/we do not qualify for uncompensated services, I/we will be personally liable for the charges rendered by provider or I/we may appeal decision in writing with additional documentation.

Signature of Patient/Guarantor: _____ Date: _____

.....
 BUSINESS OFFICE Discount Assistance Granted: _____

Approved by: _____ Date Approved: _____

LOCATION: _____ Other Supporting Documentation: Tax Filing or W2

Promissory Note

- I. For Services Received, _____ ("Maker") by this promissory note ("Note") hereby unconditionally promises to pay to the order of Advanced Orthopaedics & Sports Medicine ("Provider"), or its successor(s) or assign(s) at 11800 FM 1960 West; Houston, Texas 77065 the principal sum with applicable late payment penalties the following:

Date of Service: _____

Amount Owed: _____

Due Date: No later than: _____

- II. All principal payable under this Note are payable in lawful money of the United States of America in immediately available funds without deduction for or on account of any present or future obligations, taxes, duties, or other charges.
- III. This note shall be governed by and construed in accordance with the laws of the State of Texas, United State of America.
- IV. For any legal action or proceeding with respect to this Note, the Maker hereby expressly authorized any action brought upon the enforcement of this Note by Provider, or its successor or assignee to be instituted and prosecuted in any Federal District Court of the United State of America in Texas, at the election of Provider, its successor or assign.
- V. In the event that any amount of the principal hereof on this Note is not paid, the Maker shall pay a late payment penalty equal to 12% on payment due assessed one day following date due.
- VI. This Note may be prepaid, at any time, in whole or in part, without penalty.

The undersigned and all other parties to this note, whether as endorsers or guarantors, agree to remain fully bound until this note shall be fully paid. No modification by either the Maker or Lender shall be binding unless made in writing and fully agreed upon by Maker and Lender.

Signature

Signature

Printed Name

Printed Name
Authorized Business Office Representative

Patient Payment Plan Agreement

PLEASE PRINT THE FOLLOWING INFORMATION:

Name: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Day Phone: _____ Alternate Phone: _____

FINANCIAL INSTITUTION: _____

ACCOUNT NUMBER: _____ CARD CODE: _____

BANK ROUNTING NUMBER (first 9 digits at bottom of check): _____

PLEASE **INITIAL** THE TRANSACTION DAY OF YOUR CHOICE:

_____ 4th Day of Each Month _____ 19th Day of Each Month

I hereby authorize a monthly bank draft on the account designated above or withdrawal from my credit card, until the balance is paid in full. The amount of the monthly draft shall be as shown below and will be changed only with my written approval. I understand that a 5% service charge or \$5.00, whichever is greater, will be added to my payments and that I can pay off the remaining balance at any time without penalty. I understand and authorize for all dishonored transactions a \$25.00 processing fee be added to the balance owed.

Starting Balance: _____

First Draft Date: _____

5% Service Charge: _____

Total Amount Owed: _____

Monthly Payment Amount: _____

Number of Payments: _____

AGREED (Signature of Responsible Party)

Date

Business Office Approval (signature)

**ATTACH A COPY OF EITHER A
VOIDED CHECK OR COPY OF CREDIT CARD**

PRIVATE PAY NOTICE

Advanced Orthopaedics & Sports Medicine has agreed to furnish the healthcare services requested by me or recommended by a provider of the practice. I agree to pay in full for services received at time of service; and further, I acknowledge and attest that I have no insurance coverage for this service or have made the sole and personal decision to not use insurance coverage I may have and will in no way file a claim for this service with any insurance company at any point in the future. I have independently made this decision.

Patient / Guardian Signature

Practice Representative

Printed Name

Date

Date