2701 Cross Timbers, #232
Flower Mound, TX 75028
6805 West Northwest Highway
Dallas, TX 75225
(972)347-4783/(972)347-4916 Fax

Patient Name: ______________________________
Address: ________________________________
City: _________ State: _____ Zip: ______________
DOB: _____________________________
SSN: ______________________________

Patient Financial & Insurance Policy

In order to reduce confusions and misunderstanding between our patient and the practice we have adopted the following financial & insurance policy. If you have any questions about the policy, please feel free to discuss it with someone at our office. We are dedicated to provide the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- Your insurance policy is a contract between you and your insurance company; the doctor is not involved.

- Southwest Pediatric Orthopedics holds numerous contracts with multiple insurance companies. Each year, on our contract date, we are required to evaluate these contracts, determine if we are willing to continue our participation with these insurance programs and continue to offer services to their participants. Some out of area insurance plans are location specific and will be verified prior to the appointment. Unless you or your health coverage carrier made other arrangements in advance, full payment is due at the time of service. For your convenience we accept: Cash, Check, American Express, Discover, Master Card, and Visa.

- As a courtesy, we will file your insurance claim for you if you assign benefits to the doctor; in other words you agree to have your insurance company pay the Doctor directly. If your insurance company does not pay the practice within a reasonable length of time, we will have to look to your for payment.

- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits (or **in-network benefits**). We will bill those plans for which we have an agreement and will only **require you to pay the authorized co-payment and applicable deductible amount at the time of your appointment**.

- If you have insurance coverage with a plan that we do not have prior agreement with, and your insurance plan has **out of network benefits** we will file for out of network benefits. You will be responsible for the percentage of your visit as outlined by your insurance company at the time of service.

- If you have insurance with a plan that we do not have a prior agreement with, and **your insurance plan does not have out of network benefits we will not prepare and send the claim.** We will provide you with the necessary information for you to file your claim. This means your insurer will send the payment directly to you. Therefore our charges for your care and treatment are due in full at the time of service.

- All health plans are not the same and do not cover the same service. In the event your health plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of statement from our office.

- For all services provided in the hospital, we will bill your health plan. Any balance due is your responsibility and is due upon receipt of statement from our office.

- For all services rendered to minor patients, we will look to the adult accompanying the patient and/or the parent or guardian with custody for payment.

I have read and understand the Financial & Insurance Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

________________________________	______________________
Name of Patient (Print or Type)	**Date**
________________________________	________________________________
Patient Representative (Print or Type)	**Signature of Representative/Date**

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Relationship of Patient Representative to Patient

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