G P GOODFRIED MD, PA

TEXAS CENTER FOR HIP AND KNEE RECONSTRUCTION

PATIENT NAME:_____

WORKERS COMP DENIAL

It is important that we know if you have filed or are considering filing a worker's compensation claim. This information significantly impacts how we process your account. Please choose the appropriate statement and sign below.

_____I was not injured on the job and I will not be filing a workers compensation.
_____I was injured on the job but I have not filed a worker's compensation claim.
_____I was injured on the job and I filed a worker's compensation claim but it was denied.
_____I am pursuing my claim
_____I have dropped my claim
_____I was injured on the job and this injury is being covered by worker's compensation

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered *a part of your treatment.* The following is a statement of OUR FINANCIAL POLICY which we require that you read, agree to and sign prior to any treatment by our physicians.

- Our office will file insurance claims for you.
- I understand any co-payments and/or deductibles required by my insurance are due at the time of service. This is required by the contract with your insurance company.
- I understand that insurance coverage/verification is not guarantee of payment. I agree that I am ultimately responsible for any balance after my insurance has paid or denied my claim(s).
- I UNDERSTAND THAT IF THE INSURANCE COMPANY DENIES MY CLAIM STATING IT IS INVESTIGATIONAL, EXPERIMENTAL, PRE-EXISTING CONDITION, AUTO RELATED OR ACCIDENT RELATED WHERE LIABILITY INSURANCE IS INVOLVED, OR ANY OTHER NON-COVERED SERVICE(S), I AM RESPONSIBLE FOR THE BILL.
- We accept cash, checks, VISA, Discover or mastercard.
- INSURANCE: ALL HMO'S AND SOME PPO'S require prior authorization (a referral #) from your primary care physician for each office visit. This is your responsibility .
  IF YOU DO NOT HAVE THIS REFERRAL NUMBER AT THE TIME OF YOUR APPOINTMENT, YOUR BENEFITS MAY BE PAID AT A REDUCED RATE OR NOT PAID AT ALL.
- We accept MEDICARE assignments.
- USUAL & CUSTOMARY CHARGES: Our practice is committed to providing the best treatment possible for our patients. We charge what we believe to be the usual and customary fees for our area. You are responsible for paying the bill in full, regardless of your insurance company's interpretation of usual and customary rates.
- MISSED APPOINTMENTS: Unless canceled at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us to serve you better by keeping your scheduled appointments or canceling at least 24 hours in advance.
- **INVESTMENT INTERESTS:** Please be aware that the physician you are about to see has an investment interest in other healthcare facilities within the community, including **Texas Spine & Joint Hospital.** He
- physician if you have any questions or concerns. You have the right to request your procedure to be performed at another facility.
- I understand that if more than one insurance company is involved (i.e, Motor Vehicle Accident or Liabilty Claim), I need to contact my insurance company regarding additional paperwork required of me before ,u claim will be processed.
- This is to inform any Insurance Company involved to pay directly to **GP GOODFRIED, MD** PA any monies

B**y Signing below,** I hereby certify that I have read, understand and agree to the above financial policy. I also hereby certify that all information given to **G P GOODFRIED, MD** PA is true and accurate to the best of my knowledge.
By Signing below, I authorize payment of medical and surgical benefits to: **G P GOODFRIED, MD PA** I understand that I am financially responsible for all charges regardless of insurance coverage.
By Signing below, I also consent to sharing the following information:

a) **Sharing Information for Purposes of Treatment:** You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with quality care and the educational/wellness programs specified in my insurance plan. (I authorize **G P GOODFRIED MD PA** to request my medical records.)

b) **Sharing of Information for Purposes of Payment:** You will share all necessary information with my insurer(s), payors(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives

(including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process (including, but not limited to claims representatives, data warehouses, billing companies).

c) **Sharing of Information for Purposes of Operations:** You will share all information necessary for ongoing operations of this office, including (but not limited to the credentialing processes, peer review, clinical research, accreditation and compliance with all federal and state laws.
My consent is freely given. I understand that I may revoke this *consent to share information* at any time if that revocation is in writing, but any disclosures given in reliance on this prior *consent to share information* will be permissible.

CONSENT FOR TREATMENT

I hereby grant permission to GP GOODFRIED, MD PA to provide medical services to him/her as they deem necessary.

_____ _____

Patient's Name (printed) Date

_____

Patient's Signature (or guardian, if a minor)

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concern

REVISED 11/10/2014