Financial Policy

Effective **01/15/2021** our practice has joined the Mednax Family. Please review the below in detail as some of our processes have changed.

Referrals: Because our Physicians are specialist all of our office visits require a referral from your PCP via Leading Reach. Please coordinate this directly with them so that all visits are covered by your plan. Failure to have a referral on file will lead to patient responsibility.

Identification: All patients under the age of 18 are required to be accompanied by a legal/ guardian and or delegate and provide a VALID picture ID/ DL or Passport.

Delegates: require a signed letter from legal guardian at each visit. A picture ID/DL/Passport will be required.

Copays/Coinsurance/Deductibles: Whoever brings the patient into the office must provide payment at time of check in and or check out.

Self Pay: Patients who are not covered by any insurance health plan at time of service will receive a 25% discount if FULL payment can be made at time of service.

Non Covered Supplies: When required there are several items of DME on stock that are not covered by your insurance. Payment is expected upon check out.

Payment Plans/Arrangements: Are handled through our Central Business Office Med Data, please contact them directly @ 1-877-511-2296

Custody/Divorce: Please provide a signed court order from a judge should you have custody related issues to our practice upon check in. It is our responsibility to follow all legal guidelines and provide immediate care to the patient.

No Shows/Missed Appointments: We require a 24 hour notice of cancellation of an appointment. Appointments not cancelled within this time frame will inquire a $25 fee.

Medical Records: We can provide a summary of records for the patient free of charge. This summary includes the most recent past two medical notes. Entire Medical Records require a $25 payment at time of request. Please allow 15 business days for distribution. ALL medical records must be picked up in our office, with a valid picture identification.

Billing: All of our billing is handled outside of the practice. Should you have any issues related to balances we ask that you contact Med Data directly at 1-877-511-2296, please make sure you have your patients name and dob handy.

Statements: Med Data will send you a text message for any balances owed. Statements are generated directly from Med Data (1-877-511-2296) we ask to contact them directly for any statement related questions.

This Financial Policy is required yearly at our practice. If you have any questions or need clarification of any of our policies please contact us at 210-692-1613.

By signing below I agree to have reviewed and understand my responsibilities as the legal guardian/guarantor of the patient.

_____ _____

Signature Date

To help your process be more time efficient in the office please fill out the form below as part of your Initial Evaluation.
This will help our physicians understand what is needed during your visit. ***PLEASE BRING TO THE APPOINTMENT***

Today's Date: _____

Patient Name: _____ Pharmacy: _____
Birth Date: _____ Age: _____ Address: _____

Reason for visit: LEFT / RIGHT / BILATERAL _____

How Did It Happen/Cause: _____
_____

Date of injury: _____ ER/Urgent Care Visit? Where _____

X-rays taken? YES NO
Do you have film/CD? YES NO

Office Staff to fill out:
Height: _____

Temp: _____

Weight: _____

Patient Birth History: (circle appropriately)
Pregnancy & Labor Normal Complications
Delivery Normal Complications
Neonatal Full Term Premature: _____ weeks

Development:
Age Sitting _____ Age Walking _____
Problems? YES / NO Describe_____
_____

Medical History: Past and Present _____
_____

Family History: YES / NO Describe _____
Other family major diseases? _____

Surgical History: Any surgeries in past? _____
_____

Are immunizations up to date? YES / NO Which are missing? _____

Is the patient in physical or occupational therapy? _____

Does the patient use any braces or other equipment? _____

Allergies to Medication: _____

Current Medications: Please write down all medications including all OTC patient is currently taking (inc. dosage)
_____ _____ _____
_____ _____ _____

Patient Name:_____

Review of Systems: Please indicate any issues at today's visit

CARDIOVASCULAR: Irregular heartbeat/ chest pain	NONE
RESPIRATORY: Shortness of breath/sweats	NONE
NEUROLOGICAL: Headaches/Blurry Vision	NONE
GASTROINTESTINAL: Painful urination/frequent	NONE
ENDOCRINE: Too hot/ too cold/ frequent thirst	NONE
CONSTITUTIONAL: weight gained/ wt. loss	NONE
HEMATOLOGY: Easy bleeding/ easy bruising/anemia	NONE
ALLERGIC/IMMUNOLOGIC: seasonal allergies/itching	NONE
PSYCHIATRIC: Anxiety/Depression/mood swings	NONE
OB/GYN: LMP _____, age of first menses_____	NONE

MUSCULOSKELETAL: Joint Pain/ Aching muscles/ shoulder pain/ swelling of joints/ joint deformities/ back pain/ neck pain/ other muscle issues? _____
_____
_____

Social History: School Name _____ Grade: _____

Does the patient attend regular classes? YES NO Problems in school, if yes describe: _____

What sports does the patient play? _____
_____

Other important activities:_____
_____

Parents: Married Divorced Separated Who does child live with: _____

Fracture Care: Depending on your insurance plan, fracture care may require an out of pocket expense for the patient. Typically the following items are NOT included in your initial assessment and may require payment at time of service.

1. Xrays
2. Casting Supplies including application
3. Evaluation/Management of separate ailment/problem.
4. Treatment of complications
5. Treatment or OV after 90 day global period.

By signing below, I acknowledge that I have read and understand the Fracture Care Policy. Any questions I have will be directed to the Office directly.

_____ _____
Signature of legal guardian Date

□New Patient
□New Insurance How well do you speak English? □Very Well □ Well □ Not Well □ Not At All

Patient Information

Name: Last	First MI	Male Female

Address	Contact Info Home: _____ Work: _____ Cell : _____ Email: _____
City Zip	Date of Birth
Name Referring/PCP MD/Phone: _____ Emergency Contact/Phone: _____	Parent Name: _____ Parent DOB: _____

Insurance Information

Patient's relationship to Insured □ Self □ Spouse □ Child	□ Self □ Spouse □ Child
NAME OF PRIMARY INSURANCE/GUARANTOR	NAME OF SECONDARY/GUARANTOR
□HMO □PPO □POS □EPO □Other	□HMO □PPO □POS □EPO □Other
Claims Mailing Address	Claims Mailing Address
Insured's Name	Insured's Name
Phone Home Work	*Phone* Home Work
Social Security # Date of Birth	Social Security # Date of Birth
Insured's Employer	Insured's Employer
Insured Employer Address/Phone	Insured Employer Address/Phone
Group No. Effective Date Policy No.	Group No. Effective Date Policy No.

Ethnicity: Hispanic or Not Hispanic Race: Asian Black White Other_____ **EMail:** _____

I hereby assign to this Practice, my physician or other healthcare professionals involved in my care, all rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available, to pay for all services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. I understand that I am responsible for all charges (hospital and/or physician) until the bills are paid in full and for the balance of charges not covered by insurance.

Signature_____ Date_____

YOU MUST BE PREPARED TO PAY YOUR COPAY AND DEDUCTIBLE AT THE TIME OF YOUR APPOINTMENT TO AVOID A DELAY IN SEEING THE PHYSICIAN

MEDICAL/BILLING RECORDS REQUEST

Please NOTE to avoid a fee you may contact your transitioning Physicians office and have them request any medical records directly.

Medical Records are given FREE of charge for the TWO most recent office visit notes produced by our office.
Medical Records that are requested in full require a $25.00 cost at time of request.
They can ONLY be picked up at our office with a valid Picture Identification from a legal guardian.
Please allow 15 total business days for processing.

Date of Request: _____ Patient Name: _____ DOB: _____

For the purpose of: _____

☐ SUMMARY OF RECORDS NEEDED- INCLUDES THE MOST RECENT TWO NOTES- NO CHARGE

☐ ENTIRE MEDICAL RECORDS: ONLY RECORDS OUR OFFICE PRODUCES (including X-Rays) NEEDED- $25.00 REQUIRED AT TIME OF REQUEST.

☐ SEND MEDICAL RECORDS TO: _____
FOR THE TRANSFER OF CARE FOR THE ABOVE NAMED PATIENT.

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral are confidential and cannot be disclosed without my prior written authorization, except as provided by law.
2. A photocopy or facsimile of this authorization is as valid as the original.
3. I may revoke this authorization at any time, which will not affect information already released. This authorization is valid for a one-year period from the date it is signed, unless stated here: _____.
4. Pediatric Orthopedic Associates of San Antonio, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____
Signature (Parent/Legal Guardian) Date