

Austin Orthopaedics, Spine and Sports Medicine Associates
4316 James Casey Ste. F-100
Austin, TX 78745
Phone: (512) 707-8544 Fax: (512) 444-2600

POLICIES AND FEES FOR MEDICAL RECORDS, X-RAY DUPLICATION, DISABILITY FORMS, AND CO-PAYS

Messages for the Nurse

If you need to discuss a medical problem over the telephone, please leave a voicemail message for your doctor's nurse including your name, telephone number, and nature of your call. Please understand that the nurses are in clinic during the day and answer their messages during lunch and after clinic hours. Please do not leave more than one message, as this will delay a response to your call.

MRI / CT Scan / Discogram / Bone Scan / EMG Policy

If your doctor has requested that you obtain one of the above tests, the testing facility will contact you directly to schedule your appointment once your insurance authorization has been received. If you have not heard from the facility within 3 to 4 days to schedule your appointment, please contact our office at (512) 707-8544. If you are a Worker's Compensation patient, please allow 7 to 10 days for insurance authorization. After your test has been performed, please call our office to schedule a follow-up appointment. **A follow-up appointment must be scheduled with the doctor, as test results are not discussed over the telephone.** When you call to schedule your follow-up appointment, please let our staff know whether you are coming in for MRI, CT scan, EMG, bone scan, or discogram results. Please be advised that it can take up to 7 days from the date of your test for our office to receive the results and films. The films must be in our office on the date of your follow-up appointment for the physician to review.

Payment of Co-pays at the Time of Service

According to your agreement with your insurance company, as well as our contract with your insurance company, you are required to make the payment of your co-pay at the time of service. If you do not pay your co-payment at the time of service, your account will be charged at \$10.00 statement fee.

Prescription Refills

Requests for prescription refills should be made through your pharmacy during office hours only. Please call your pharmacy at least one day before you are finished with your prescription. Allow up to twenty-four hours for the refill to be processed, as your physician's signature is required.

Request for Completion of Disability Forms

If you have insurance forms or any other medical form that needs completing, there is a charge of \$5.00 per page for the first three pages, and \$7.00 for each additional page, which must be paid prior to completion. You must allow ten working days for processing. Completed forms must be picked up from our office, being that we do not mail or fax the forms to any other entity.

Request for Medical Records

We require a twenty-four hour notice for request of medical record copies. There is a \$10.00 charge for copies of your medical records, which is due before the records are released. There are additional fees associated with requests for records from attorneys, insurance companies, or other entities.

Request for X-Ray Duplication

We require a twenty-four hour notice for duplication of your x-ray films. There is an \$8.00 charge per sheet for copies of your x-rays that must be paid in advance. You can sign your films out of the office, but you are required to pay, in cash, a refundable fee of \$8.00 per sheet. The fee will be refunded when the x-rays are returned to our office. We are required by Texas law to keep our original films in this office for seven years.

The above office policies for medical record copies, x-ray film duplication, and disability form completion fees are set in accordance with Texas Medical Board regulations.

I have been advised of the above policies and understand and agree to the fees associated with such requests.

Patient / Guardian Signature

Date

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OFFICE POLICY ON STANDARD INSURANCE & MANAGED CARE INSURERS

In order to accommodate the need of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult to keep track of all the individual requirements. Even within the same insurance company, the plans differ depending upon what type of contract your employer negotiated. Providing quality medical care for our patients is our primary concern. We are more than willing to provide the care within your insurance contract if you let us know EACH date of service follows your policy's guidelines. We highly recommend that you READ YOUR INSURANCE BOOKLET or contact your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, pre-existing conditions, etc. **You are responsible for the payment of your account.**

HMO / PPO (PCS, United Healthcare, BCBS, Cigna, etc.)

If the doctor is a provider for your plan, we will file the claim for you. You are responsible for any co-payments and/or deductible at the time of your visit. If your plan requires prior authorization to see a specialist, the patient is always responsible for getting the office referrals before the day of your appointment. You will be billed personally, not your insurance company, for any non-authorization office visits.

MEDICARE

Medicare pays 80% of the allowed charge, after your annual deductible is met. The patient is responsible for the other 20%. We will file your secondary insurance if you provide the information at the time of your visit.

UNINSURED / SELF PAY

Payment is expected at the time of service. If you are unable to pay in full, please contact our office prior to your visit in order to establish financial arrangements.

AUTO ACCIDENT / LOP

We must have your Personal Injury Protection (PIP) insurance information prior to your initial visit. The patient must also sign an Assignment of Proceeds which will be mailed to your claims adjuster, and/or your attorney, if applicable. We cannot accept private health insurance on a liability claim.

I have read and understand the above information.

Patient / Guardian Signature

Date

Austin Orthopaedics, Spine and Sports Medicine Assoc.

NEWTON HASSON, M.D.

WILLIAM RODEN, M.D.

Office
4316 JAMES CASEY, SUITE F-100
AUSTIN, TEXAS 78745
PH: (512) 707-8544
FAX: (512) 444-2600

AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

By signing this form, I authorize Austin Orthopaedics to use and disclose the protected health information described below.

Patient Name: _____

The health information you may release subject to this authorization is as follows:

Release my protected health information to the following person(s)/entity:

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

The reasons or purposes for this release of information are as follows:

This authorization shall be in forced and effective until the following event and/or date:

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice:

Austin Orthopaedics
4316 James Casey, Suite F-100
Austin, Texas 78745
(512) 707-8544

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

Patient/Guarantor Signature: _____

Date: _____

Name of Patient or Personal Representative: _____

Description of Personal Representative's Authority: _____

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NEWTON HASSON, MD

WILLIAM RODEN, MD

ACKNOWLEDGEMENT OF REVIEW OF
NOTICE OF PRIVACY PRACTICE

I have reviewed Austin Orthopaedics, Spine and Sports Medicine Association's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

Patient/Guarantor Signature: _____

Date: _____

Name of Patient or Personal Representative: _____

Description of Personal Representative's Authority: _____