

Matthew P. France, MD

Fellow American Academy of Orthopaedic Surgeons • Arthroscopy Association of North America Diplomate American Board of Orthopaedic Surgery • Fellowship Trained Shoulder and Knee Specialist

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FINANCIAL AGREEMENT

Your health insurance policy is a contractual agreement between you and your insurance carrier. It is, therefore <u>your</u> responsibility to question your insurance company regarding delays in payment and / or denial of coverage, as well as any requirements that may be included in your insurance policy coverage (i.e.: pre-certifications, physician networks, referrals, co-insurances, deductibles...). We will (in most cases) bill your insurance company of record for services initially, this may or may not absolve your financial responsibility.

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With regard to the medical services to be performed on my behalf by Matthew P. France, MD, I understand and agree with all the following:

- Outstanding balances as determined by my insurance carrier are my responsibility and are due immediately. I am ultimately responsible for any <u>allowed</u> charges not covered by my insurance company(s).
- 2) I authorize direct payment to Matthew P. France, MD of any insurance benefits otherwise payable to me or on my behalf for services performed by Dr. France. This Assignment of Benefits is valid for all payors including Medicare.
- 3) I authorize the release of any information necessary for the processing of any medical claims
- 4) I understand that I will be responsible for a fee of \$30.00 for each check written to Dr. France that is returned by my financial institution for insufficient funds.
- 5) If the services of a collection agency and/or attorney are utilized to collect all or any portion of the outstanding balance, I will be responsible for a \$30.00 fee to cover the processing/forwarding of this account to the collection agency. An additional 25 percent of the balance forwarded to collections will be billed to my account to cover this ongoing collection expense.

Signature:	
Date:	
Please print your name:	
Name of the patient (if a minor):	
Relationship to the patient:	

Arthroscopic Surgery & Sports Medicine Center (ASSMC): Notice of Privacy Policies

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review the below carefully.

At ASSMC we are committed to treating & using protected health information about you responsibly. This notice describes the personal information we collect and how & when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective 3/15/03 and applies to all protected health information as defined by federal regulations.

<u>Understanding your health record:</u> Each time you visit our office a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnosis, treatment plan and recommendations. This information, often referred to as your health or medical record, serves as a: basis for planning your care / treatment, means of communicating with other health professionals regarding your care, legal documents describing the care you received, means by which an insurance company can verify services billed were actually provided, source of data for medical research, source of information for state/federal public health officials, a tool with which we can assess & continually work to improve the care we render and outcomes we achieve. Understanding what is in your record and how your health information is used helps you: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

<u>Your health information rights:</u> Although your health record is the physical property of ASSMC, you have access to this information. You have the right to: obtain a paper copy of this notice of information practices (hanging on wall by front entrance are copies), obtain a copy of your health record, amend your health record if incorrect, obtain an accounting of disclosures, request restrictions on certain uses and disclosures of your information & revoke your authorization to use or disclose health information except to the extent that action has already been taken.

<u>Our responsibilities:</u> ASSMC is required to: maintain the privacy of your health information, provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices & to make the new provisions effective for all protected health information we maintain. Should our practices change we will notify you in writing during your next office visit. We will not use or disclose your health information without your authorization, except as described in this notice. We will discontinue to us or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

<u>For more information or to report a problem:</u> If you have questions and would like additional information you may contact our Privacy Officer at 908-722-1122. If you believe your privacy has been violated, you can file a complaint with our Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either aforementioned.

Examples of disclosures for treatment, payment and health operations: We will use your health information for treatment purposes; we will use your health information for regular health operations; we will use your health information to communicate to authorized family members / guardians; we will use your information to communicate with your insurance company &/or workmans' compensation carrier and nurse case managers; we will use your health information to communicate with appropriate public health / law enforcement departments as mandated; we will use your health information to respond to valid legal subpoena's.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

~ HIPAA Patient Consent Form ~

Patient consent to the use and disclosure of health information for treatment, payment or healthcare operations.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via facsimile. I authorize the office to contact me at any of my personal phone numbers (home &/or cell phone) listed in this chart and authorize them to leave detailed information regarding my medical care.

I fully understand and accept the terms of this consent.

Patient Printed Name:______

Patient / Parent or Legal Guardian Signature:_______ Date:______

Please list below any restrictions to the release of this medical file:

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For office use only:	Consent rec'd by:	Date:	

Financial Policy:

We are committed to the success of your medical treatment and overall pleasant experience. Please understand that payment for medical services rendered is part of the process. In most instances, and as a courtesy, we will directly bill your insurance carrier and not expect payment at the time services are rendered. The balance after all insurers have considered the claim however is your responsibility with the exception of Workers' Compensation

Please be sure to bring information for all insurance policies providing coverage. We will be happy to forward any balances to secondary or tertiary insurance carriers. If your coverage changes you will need to inform our office staff of the new carrier and effective date.

dispute regarding the fees charged and their definition of "usual and customary" is between you and your insurer. If you are not satisfied insurance company. The insurance policy is between you and your carrier, not with the office. For nonparticipating insurances, any It is your responsibility to be familiar with your insurance coverage. We render medical services to you, the patient, and not to the with the insurance payment it is your responsibility to contact the carrier.

If needed, payment plans are available. Please contact our billing office to inquire about this option.

For your convenience below are some frequently asked questions. If you need further information or have additional questions please do not hesitate to contact the office at 908-722-1122

How may I pay my bill?

We accept cash or checks; however, if sending payment via mail please DO NOT send cash and your correspondence should be directed to the following address:

Arthroscopic Surgery & Sports Medicine Center 720 Route 202 / 206 North Green Knoll Professional Park, Building 2 Bridgewater, NJ 08807

What insurance plans do you participate with?

Contact the office to clarify your insurance plan participation. Please note:

For all valid insurance coverage, we will submit your claim for services to your private insurer. We will not expect -We do not participate with nor do we forward billings to. Medicaid or Motor Vehicle Carriers (PIP claims) payment at the time services are rendered

yearly deductible and / or the 20% co-insurance they do not cover. If you have a secondary insurer we will be happy We will bill Medicare for medical services rendered, however you are responsible for the to send the balance of the bill to them for consideration. -Medicare participants:

What if I was injured at work?

The adjustor for your employer's insurance company is responsible for scheduling your initial appointment. We cannot schedule directly with the injured worker until authorization and appropriate information is received from them.

What is the financial policy if your office has chosen not to participate with my insurance and I need surgery?

Please do not allow non-participation with your insurance carrier to stop you from proceeding with surgery as most policies provide out-ofnetwork benefits. In fact, the majority of Dr. France's surgical patients are out-of-network. Simply call our office at 908-722-1122 inform the staff of any deductible & lor co-insurances your policy contains and we will be more than happy to discuss any, if at all, anticipated financial responsibility that you may have.