



**Deborah A. Faryniarz, M.D., Inc.**

*Sports Medicine and Shoulder Fellowship,  
The Hospital for Special Surgery,  
FORUM, Society of Fellowship Trained  
Women in Orthopaedic Surgery*

**Grady L. Jeter, M.D., Inc.**

*Member Arthroscopy Association of North America,  
International Society of Arthroscopy,  
Knee Surgery and Orthopaedic Sports Medicine,  
Founding Member Ikeuchi International Society for Arthroscopy and  
Musculoskeletal Endoscopy*

**Martin Trieb, M.D., Inc.**

*Member Arthroscopy Association of North America*

*Diplomates American Board of Orthopaedic Surgery • Members American Orthopaedic Society for Sports Medicine  
Fellows American Academy of Orthopaedic Surgeons*

## **Office and Financial Policies**

Thank you for choosing the Arthroscopy and Sports Medicine Clinic for your sports and orthopaedic care. To keep you informed of our current office and financial policies we ask that you read and sign our office and financial policies prior to any treatment. Please keep this document for future reference.

**Credit Card Policy:** The Arthroscopy and Sports Medicine Clinic requires a valid credit card or bank debit account information prior to services being rendered. Your credit card or account will not be charged until your health insurance carrier has paid and the balance deemed your responsibility.

**Cancelled Appointments:** As a courtesy to other patients waiting for appointments, please give us at least two weeks notice if you need to reschedule. There will be a \$50.00 same day cancellation fee required for cancellations made less than 24 hours in advance.

**Cancelled or Rescheduled Surgical Procedures:** As a courtesy to other patients waiting for surgery, please give us at least two weeks notice. The need to cancel or reschedule your surgical procedure within one week of surgery will result in forfeiture of your deposit.

**Surgical Assistant:** Should you require surgery, an assistant familiar with Dr. Faryniarz's instruments and techniques will be provided. The assistant may be another physician or a physician assistant. The usual fee for the assistant surgeon is approximately 20% of the surgeon's fee. Some insurance carriers do not provide benefits for assistant surgeons. Where insurance carriers deny coverage, we will reduce the fee to \$450.00; this will be collected as your deposit at the time of booking surgery to hold your surgical date. It is 100% refundable if you cancel at least one week prior to your scheduled date. As a service our staff will bill your insurance carrier, and if paid, will issue a refund or apply it towards your surgical balance.

**Disclosure:** Dr. Faryniarz has a beneficial interest in Silicon Valley and Bascom Surgery Center. If this is of concern and you wish to have your procedure at a different facility, please discuss this with Dr. Faryniarz.

**No Insurance:** Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our Financial Counselor. We do offer payment plan options.

**Insurance:** Please bring your insurance card with you at the time of your appointment. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. All questions regarding insurance coverage and reimbursement should be directed to your insurance carriers.

You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance. The estimated cost will be collected at the time of service. As a service, we will bill your primary insurance for you. We make an effort to keep up with all the rules and regulations of each insurance company; however, ultimately, as the patient, you are responsible for making sure your insurance pays in a timely fashion. You will be responsible for the bill if your insurance company does not pay within 60 days. After 60 days, you will be responsible for the full amount in 30 days. Unpaid balances over 90 days will be assessed 1% compounded monthly interest unless other arrangements have been made and

outstanding balances over 120 days will be processed by a collection agency. Dr. Faryniarz offers payment plan options if your care will cause you financial hardship.

**DME:** Durable medical equipment (DME), such as braces and ice machines, are handled through an outside vendor. Our office will help with authorization of recommended DME; however, it is your responsibility to check with your insurance benefits for coverage of the equipment.

**Auto Accident Injury:** We do not accept auto accident liens. Payment for any services rendered will be your responsibility.

**Return Checks:** A \$30.00 charge will be added to your account for any check returned by your bank.

**Disability or Insurance Forms:** There will be a charge of \$15.00- \$35.00 for the completion of medical forms. Payment is due at the time that you pick-up the forms. Please allow 7-10 days for the completion of these forms. If you would like the forms mailed to you or your insurance company, payment will be due prior to mailing.

**Medical Records:** We will provide you a copy of your medical record upon request. You will need to sign a letter of release at the time of pick-up. Please allow one week for us to copy your records. Depending on the extent of your record, there may be a small charge of \$25 for copying and/or mailing your records.

### **Patient Financial Responsibility**

I acknowledge full financial responsibility for services rendered by the Arthroscopy and Sports Medicine Clinic. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance. I understand payment of co-pays is expected at time of service, as well as any prior balance I may owe. I also consent that the payment of authorized Medicare insurance benefits be made on my behalf directly to Arthroscopy and Sports Medicine Clinic for any medical or surgical services furnished. I agree to all reasonable attorney fees and collection costs in the event of default in payment of my charges, as outlined in the office and financial policies guidelines.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### **Acknowledgment – Notice of Privacy Practices**

I hereby acknowledge receipt of Arthroscopy and Sports Medicine Clinic's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential health information.

I understand that the Arthroscopy and Sports Medicine Clinic has reserved the right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided or made available to me.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If you are not a patient, please specify your relationship to the patient \_\_\_\_\_