ARTHROSCOPY & SPORTS MEDICINE CLINIC

Deborah A. Faryniarz, MD Inc.
• Sports Medicine and Shoulder Fellowship, The Hospital for Special Surgery
• FORUM, Society of Fellowship Trained Women in Orthopaedic Surgery
• Diplomat American Board of Orthopaedic Surgery
• Member American Orthopaedic Society for Sports Medicine
• Member Arthroscopy Association of North America
• Fellow 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. This will be available in your digital chart. You may request a copy at any time.

Credit Card Policy: The Arthroscopy and Sports Medicine Clinic requires a valid credit card or bank debit account information prior to services being rendered. Credit card refunds will be subjected to a 5% charge to cover credit card fees.

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. Cancelling or rescheduling 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 $475.00; 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 courtesy, our staff will bill your insurance carrier. If paid, we will issue or apply the credit towards your surgical balance.

Disclosure: Dr. Faryniarz has a beneficial interest in National, Silicon Valley and Bascom Surgery Center. These centers have personnel that are familiar with the procedures she performs and use equipment she has preapproved. If this is of concern and you wish to have 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. For out of network insurances, you will be reimbursed directly by your insurance carrier and therefore will be required to pay for services at the time of your visit. 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 a 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 within 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 your insurance benefit 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 $25.00- $45.00 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. There will be a charge of $25-$50 for copying and/or mailing your record, depending on the extent of 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 my co-pay is expected at time of services, as well as any prior balance I may owe. I also consent that the payment of authorized medical 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: _____