



Paul A. Dowdy, M.D.

Board Certified in Orthopaedic Surgery
Specializing In Sports Medicine, Arthroscopic
Surgery, Reconstruction of the Shoulder & Knee

OUR OFFICE POLICY

Phone (352) 243-7411

Fax (352) 394-4257

2113 Ruby Red Blvd., Suite A

Clermont, FL 34714

Patient Name: _____ Date of Birth: _____

BASIC POLICY Pay for service is due in full at the time service is provided in our office.

FOR PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also file most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you. HMO patients, it is your responsibility to obtain authorization from your PCP prior to being seen and to provide our office with the name and address of your PCP.

MEDICARE PATIENTS We will bill Medicare for you. All copayments or deductibles are due and payable at the time service is provided. We will file secondary insurances, for your reimbursement, as a courtesy.

MEDICAID PATIENTS We will bill Medicaid for you. Medipass does require authorization from your Primary Care Physician prior to being seen. Copayments are due and payable at the time service is provided.

SURGERY FEES All copays, deductibles, and payments for noncovered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier. Self pay surgeries require 50% deposit prior to scheduling surgery.

NONCOVERED SERVICES Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

AUTO ACCIDENT CASES If you are injured in an auto accident, we will need the claim number and insurance carrier. Deductible and copay are due and payable at the time services are rendered.

WORKER'S COMPENSATION If your injury is work-related, we will need a copy of notice of injury, the case number and carrier name prior to your visit in order to bill the worker's compensation insurance company.

MEDICAL RECORDS FAX I authorize Cypress Orthopedics to transmit my medical records electronically. If they are received by another party in error, I absolve Cypress Orthopedics of any and all liability relating to such submission of said records.

PATIENT PRIVACY As Federal HIPAA regulations are going through the implementation phase, great emphasis is being placed on privacy and confidentiality. In order to protect the privacy of our patients and the confidentiality of medical information, we are implementing procedures to restrict access to patient information. Any request for copies of a patient's chart will need a written request from the patient and an address of where the copy of this patient's record is going. Anyone calling for information from a patient's appointment record, work status, or any information pertaining to a patient must first identify the patient with the date of birth and social security number of the patient. Patients needing x-rays taken in this office will be charged a minimal fee for copies of the x-rays, therefore the original x-ray will remain a permanent record in this office. These procedures are keeping with standards set by the HIPAA guidelines.

Signature: _____ Date: _____

Please check one: I have paid my insurance deductible or premiums for the calendar year. Yes No Don't Know

CONSENT FOR TREATMENT AND LIFETIME AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby give consent to Cypress Orthopedics to provide whatever treatment they deem necessary to the patient.

I certify that the information I furnish is true and correct. I am fully aware that it is a felony to falsify any information relating to my medical condition.

I hereby authorize Cypress Orthopedics to submit a claim to my insurance carrier, or its intermediaries for all covered services rendered by the physician(s). I also authorize my insurance carrier, or its intermediaries to issue payment directly to the physician(s). A photocopy of this assignment is considered to be as valid as an original.

I hereby authorize Cypress Orthopedics to furnish complete information requested by my insurance carrier, or its intermediaries regarding services rendered.

I further agree that I am responsible for payment of any remaining balance after insurance payments have been made, including any collection costs (Collection Agency fee is 30%) or legal fees incurred to collect these balances.

Signature of Patient: _____ S.S.# _____ Date: _____

Signature of Responsible Person (If Other Than Patient): _____ S.S.# _____ Date: _____