L.D. Jennings, M.D.
Board Certified Orthopaedic Surgery
Board Certified Sports Medicine

NOTE TO MEDICARE PATIENTS: Medicare may not pay for certain durable medical equipment that the doctor feels is necessary for your treatment. Payment for these items will be required at the time of service, or a prescription may be given to obtain the item at a contracted location.

Filing Insurance Forms **Patient Name**_____

Thank you for choosing Texas Knee and Sports Medicine Center. As an added service, we can file your insurance claims for you to reduce out of pocket payment required at the time of your visit. To use this service and avoid payment in full at the time of service, you must provide the following:

- Proof that your deductible has been met for the current contract year,
- Proof that your co-insurance amount has been met. This co-insurance amount may be required for specific services lined out in your plan in addition to any co-payment required for office visits.

***** Services not covered by your copay may include, but are not limited to, x-rays, injections, casts, resetting fractures in the office, durable medical equipment (heel pads, braces, etc), and any other procedures performed in office other than evaluation.**

You are responsible for knowing your insurance benefits. Each Patient and each Guarantor agree that payment in full is due at the time of receipt of medical services if the insurance indicates that out of pocket expenses have not been met**. Dr. Jennings and Texas Knee and Sports Medicine Center may submit claims for services rendered to your insurance carrier(s), but such submission does not forgive or reduce any sums due and Patient and Guarantor agree that they are only entitled to a credit for the dollar amounts of the payments actually received from such insurance carrier(s), and that the remainder of the balance is due in full at the time of receipt of the statement.** Each Patient and each Guarantor agree that all balances are subject to accrual of interest at the highest rate allowed by law from and after the 90th day following the date of patient's receipt of medical services**.**

Patient_____

Guarantor_____

BECAUSE OF THE NATURE OF MEDICAL PRACTICE, CANCELLATION OR RESCHEDULING NOTICE OF LESS THAN 24 HOURS IS SUBJECT TO A $30.00 CANCELLATION FEE.

Disclosure of Financial Interest

This paragraph is to disclose that L.D. Jennings, M.D. has a financial interest in the following facilities: Texas Health Center for Diagnostics & Surgery, Plano, Texas, Texas Health Presbyterian Hospital of Flower Mound, Flower Mound, Texas and Greater Therapy Centers, Carrollton, Texas. Dr. Jennings wants you to know that you have the option, at your discretion, to use an alternate health care facility or imaging center. Please indicate below your receipt of this Notice by your signature.

_____ _____

Patient (or Guardian) Signature **Date**

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Accident Details **Patient name**_____

Insurance companies require information about how you were injured. They would like to have this information in your writing. Please complete every line of this form, as this information will be sent to your insurance company, in the event that it is requested, to expedite claim processing.

Date injury occurred_____ What body part was injured_____

Where injury occurred_____

Please circle one: Is this a work injury? YES/NO
Is this a third party liability claim (auto accident/business liability) YES/NO

In your own words, describe how the injury happened in detail_____

_____

Consent for use and disclosure of information

I have reviewed the "Notice of Privacy Practices" of **Texas Knee and Sports Medicine Center, P.A.** and have had all questions answered by this office. I also consent to the use or disclosure of my protected health information for the following purposes:

- **Treatment**
  It will be necessary to share protected health information with all members of the treatment team for treatment purposes. This can include employees in this office as well as other providers.
- **Payment**
  Necessary information will be shared with appropriate payer sources and their representatives for payment purposes including, but not limited to, eligibility, benefit determination, and utilization review. It will also be necessary for your billing personnel including, but not limited to employees, case managers, claims representatives, third party billing services or clearinghouses to have access to protected health information to carry out their job functions.
- **Healthcare operations**
  Necessary information will be shared for the continuing operations of this office. Some examples include, but are not limited to, peer review, accreditation, credentialing processes, and compliance with all federal and state laws.

I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing which will apply to disclosures and uses made subsequent to the revocation date.

_____ _____

Patient (or Guardian) Signature **Date**