Texas Knee and Sports Medicine Center

L. D. Jennings, M.D.
Board Certified Orthopaedic Surgery
Board Certified Sports Medicine
4323 N. Josey Lane, Plaza I, Suite 307
Carrollton, TX 75010
Phone: 972-394-0118 Fax: 972-394-1058

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ Date of Birth: _____
Last Name First Name

Email address: _____

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, x-ray, DME, physical therapy, injections, casting and any other medical procedures ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Office to know if my insurance will pay for my medical service or visit, x-ray, DME, physical therapy, injections, casting or any other screening service or diagnostic testing ordered by the physician or physician's staff.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out of network amounts, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment at the time of service.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP (primary care physician) choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

I understand that the physician may charge a $35.00 fee if I do not show up for my follow up appointment, or if I cancel without a 24-hour notice. I understand that if I cancel or reschedule my surgery after it has been scheduled I may be charged a cancellation/reschedule fee of $100.00.

Signature: _____ Date: _____
(Please sign here – Patient or Responsible Party)

Responsible Party Name: _____ Relationship: _____
(Please print name of Responsible Party if different from Patient)

Texas Knee and Sports Medicine Center

L. D. Jennings, M.D.

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Texas Knee and Sports Medicine Center, or the physician individually for services rendered to my dependents, or me, by the physician or those under his supervision. I understand that it is my responsibility to know my insurance benefits whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Texas Knee and Sports Medicine Center, is unable to collect from my insurance carrier for whatever reasons.

AUTHORIZED TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify and I have read and been offered a copy of Texas Knee and Sports Medicine Center "HIPAA Notice of Privacy Practices". I hereby authorize Texas Knee and Sports Medicine Center or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL, OR EMAIL:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Texas Knee and Sports Medicine Center representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointments, referral arrangements, and diagnostic test results. I understand that I have the right to resigns this authorization at any time by notifying Texas Knee and Sports Medicine Center to that effect in writing.

DME/X-RAY/MEDICAL PROCEDURES/PHYSCIAL THERAPY:
I understand that I may receive a separate bill if my medical bill includes DME, x-ray, medical procedures, or physical therapy. I further understand that I am financially responsible for any co-pay/deductibles/co-insurance, or balances due for these services if they are not reimbursed by my insurance or whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by Texas Knee and Sports Medicine Center or those under his supervision.

SURGERY DEPOSIT:
I understand that I am responsible for 100% of the surgery deposit at the pre-operative appointment. If I am unable to provide full payment, a deposit can be discussed and agreed upon based on individual situations. In those cases, credit/debit card for automatic payments will be required along with a signed payment agreement.

DISCLOSURE OF FINANCIAL INTEREST:

This disclosure covers entities that L. D. Jennings, M.D. has a(n) ownership/interest in: Texas Health Center for Diagnostics & Surgery of Plano, Texas, and Texas Health Presbyterian Hospital of Flower Mound, Texas. In addition, he has ownership/interest in MJ Surgical, PLLC. Services for the latter may be out of network and, as a result, you may receive an out of network bill. You have the option, at your discretion, to use an alternate health care facility or imaging center. You will not be treated differently by Dr. Jennings or Texas Knee and Sports Medicine Center.

PATIENT SIGNATURE: _____ DATE: _____

GUARANTOR SIGNATURE: _____ DATE: _____

(If different from patient)

GUARANTOR NAME (Please print): _____

REFERRAL SOURCE: (please circle one)

Friend/Family Member Insurance Website Google Social Media

Doctor: _____ Other:_____

PHARMACY INFORMATION:

I understand that the State of Texas now requires certain prescriptions to be sent to the pharmacy electronically.

Please provide below your preferred pharmacy and your personal e-mail for ePrescribe.

PHARMACY NAME & STORE NUMBER: _____

PHARMACY ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PHARMACY PHONE NUMBER: _____

*****If the pharmacy information is not filled out in detail this will delay processing of all prescriptions*****

Texas Knee and Sports Medicine Center

L. D. Jennings, M.D.

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, if it is requested, to expedite claim processing.

Please circle one: Is this a work injury? YES NO

Is this a third party liability claim (auto accident/business liability) YES NO

Date injury occurred: _____

What body part was injured? _____

Where injury occurred:

_____

In your own words, describe how the injury happened in detail:

_____

_____

_____

_____

AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance; however, you are responsible for your co-pay and/or percentage, which the insurance company is not liable for on the day of your visit. In the event that your insurance company has not paid within 60 days, you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physicians when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable.

I have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, to be paid to the physician. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physician to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, medical assistant, and physical therapist and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

_____ _____

Signature Date

I authorize this facility to release information to (Please check all that apply):

- Spouse: (List full name of spouse) _____
- Children (List full names & phone numbers) _____

  _____
- Others: (List complete name & phone number) _____

  _____
- No one

_____ _____

Signature Date