DALLAS SARCOMA ASSOCIATES, PA
Financial Policy/Consent to Treat

Do you have a secondary insurance or more than one insurance? (Circle) **Yes/NO**

Payment:

Payment is due at the time of service. If you have insurance, your co-pay and/or deductible along with any co-insurance amount will be collected prior to seeing the physician. For all services rendered to minor patients, we will look at the adult accompanying the patient and the parent or guardian with custody for payment. For all services rendered on a in-patient basis (hospital or surgery) an estimate will be given to the patient prior to services and a deposit will be collected prior to any services performed. If any installment arrangements must be made, they should be made at this time. We accept American Express, Visa MasterCard, Discover, cash and checks.

Insurance:

If we are a participating provider for your insurance company we require you to first meet your co-pay, deductible, and/or any part that your insurance does not pay at the time of service. Most misunderstandings about insurance can be avoided if you understand what your policy provides**.** If your insurance company chooses not to Pay Dallas Sarcoma Associates P. A. for whatever reason or they choose to delay payment, you will be responsible for payment. If payment is not received with 45days from your insurance company, you will be responsible for the outstanding balance. Our office will assist you, as our patient in filing your claims with those insurance companies we are contracted with, after obtaining all insurance information needed from you. Ultimately, you are responsible for your insurance and/or your bill.

Assignment of Benefits:

I hereby authorize Dallas Sarcoma Associates PA all payment for surgical and medical services rendered to myself or dependent. I understand that I am responsible for any amount not covered and/ or denied by my insurance.

Medicare Assignment:

I hereby request that payment of authorized Medicare Benefits be made to Dallas Sarcoma Associates PA for services provided.

Out of Network Insurance:

If you have insurance coverage with a plan that we do not have a prior agreement with, we will prepare a statement with all information needed for you to file with your insurance company. Charges for your care and treatment, including surgery, are due in full at the time of service.

Insurance Carriers Requiring Referral Numbers (POS. EPO. HMO. MEDCAID):

If your insurance carrier requires you to have a referral number prior to your seeing a specialist, our office must be in receipt of that referral number 24hrs in advance. If we do not have this upon your arrival, your appointment will be rescheduled to a later date. You are responsible for obtaining all referrals prior to your appointment.

Returned Checks:

There will be a $25.00 charge for all returned check. If a check is filed with DA's office for collection, all fees incurred in the filing will be your responsibility as well. After any check has been returned for Non-Sufficient funds, payments to our office will be on a cash basis only.

Outpatient Procedures Ordered:

Patients are financially responsible for any outpatient procedure(s) ordered by their physician,

Assistant at Surgery:

As Dr. Casas usually requires an assistant, our certified physician assistant, during surgery. A separate bill for our assistant will be sent to all insurance plans. You will be responsible for any deductible/co-insurance as required by your policy. If you have no insurance: in addition to Dr. Casas' fees, 16% of physicians total charges will be required by you to pay prior to your date of surgery for our assistant at surgery. Please be advised not all insurance plans cover an assistant at surgery.

Consent to Treat:

I hereby grant Dallas Ft. Worth Sarcoma Group, PA and its associates the authority to treat and examine me/my dependant, and order any examinations, tests, treatments and other clinical services necessary for my care and treatment.

No Show Policy:

There may be a $25.00 dollar charge for all patients who do not cancel their scheduled appointment with 24hrs notification. There will be a fee for Medical Records and for Patient Forms that would not be covered by your insurance carrier. You will be personally responsible and payment will be due upon receipt of statement.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. until further notice. I also understand and agree that such terms may be amended from time-time by the practice.

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Patient Signature/Parent for minor/Power of Attorney Date

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Print Patient Name Witness to Signature

If the patient is unable to sign, state reason:_____