EVANGELISTA ORTHOPEDIC CLINIC

Gregory T. Evangelista, M.D.
Perry J. Evangelista, M.D.
3271 N. Civic Center Plaza, Suite 110
Scottsdale, AZ 85251
Phone: (480) 656-0291 Fax: (480) 656-0127

PATIENT CONSENT

PAYMENT POLICY

Thank you for selecting us as your orthopedic services provider. We are committed to quality, affordable health care, with the goal of returning you to your normal routine as soon as possible.

This payment policy has been developed to provide you with the general information you need to fulfill your financial responsibility for the services we provide.

Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance: We participate in many insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. If you would like help in determining the status of your coverage we will be pleased to assist you. If you would like to arrange for a different payment option please speak with us in advance of your visit.

2. Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service unless other arrangements are made in advance of your visit.

3. Non-covered services: Please be aware that some, and perhaps all of the services you receive may not be covered, or may not be considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.

4. Proof of insurance: All patients must complete our patient information form before seeing our staff. We must obtain a copy of your driver's license and current valid proof of insurance. It is important that you provide us with the correct insurance information in a timely manner. Failure to do so may result in the balance of a claim becoming your personal responsibility.

5. Claims submission: We will submit your claims and assist you in any way we reasonably can to have your claims paid. Your insurance company may need you to supply certain information to them directly. Prompt compliance with this request will minimize issues and help ensure prompt payment. Please be aware that any remaining claim balance is your responsibility.

6. Coverage changes: If your insurance situation or coverage changes, please notify us before your next visit. This will allow us to make the appropriate changes, avoid inconvenience and help ensure that you receive all the benefits to which you are entitled.

7. Payment: We accept cash, most credit and debit cards and personal checks.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

I have been presented with the Notice of Privacy Practices and am aware that I can access a copy on the website and/or patient portal. I understand that Evangelista Orthopedic Clinic has the right to change its Notice of Privacy Practices from time to time and that I may contact Evangelista Orthopedic Clinic at any time to obtain a current copy.

Authorization for Release of Health Information:

I hereby authorize Evangelista Orthopedic Clinic to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care. I also authorize the release of information that may be necessary in the processing of any insurance claims.

I hereby authorize Evangelista Orthopedic Clinic and its Employees permission to discuss, send and/or receive my personal health information to/with the following individual(s):

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

ACKNOWLEDGEMENT: By signing below, I acknowledge that I have read and that I understand the disclosures contained in this “Notice to Patients” form.

Dated this _____ day of _____, 20_____.

_____

Signature of Patient or Guardian