San Antonio
Hand to Shoulder
Orthopaedic Center

Mark A. Katz, M.D.
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Financial Responsibility

If you are a Workman's Compensation patient, please disregard the Notification of Financial Responsibility and the Statement of Financial Responsibility below.

Notification of Financial Responsibility:

All patients are financially responsible for the payment of services rendered by Mark A. Katz, M.D. Payment is expected at the time services are rendered, unless arrangements are made prior to the visit. These payments include co-pays, deductibles, and coinsurance. You are also responsible to provide payment for any remaining account balances that may be outstanding on your account.

If timely payment is not made for your account, interest will begin to accumulate after 90 days of overdue payments. A **12% interest rate will be added to the past due balance.** After 120 days, your account will be sent to a collection agency, and there will be a **30% collection fee added to your existing balance.** All returned checks for insufficient funds will result in a $25.00 charge to your account.

Statement of Financial Responsibility:

I have carefully read and understand that I, _____, am financially responsible for the payment of all charges pertaining to the services rendered by Mark A. Katz, M.D.

Guarantee of Payment:

Please Initial below:

_____ I understand that I am totally responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities.

_____ I have been advised that if my health insurance carrier (PPO/HMO/Medicare plan) claims that services I received today are not considered reasonable and medically necessary for my care, I will be responsible for payment of these services.

_____ I understand that if I am participating in an HMO plan, my primary care physician (PCP) must authorize the services that I am requesting and receiving today. I have been advised that if I did not notify my PCP in advance for a referral authorization, my HMO plan may deny payment for services; and thus, I will become responsible for payment of all services.

_____ I understand that if my insurance company does NOT deem the services I received as "a covered benefit," I will be responsible for payment of these services.

NOTE: The guarantor of each patient account is ultimately responsible for payment in full. If your insurance company does not pay in a timely manner (within 90 days of the date of insurance filing), the guarantor of the account will be expected to pay the balance owed and then pursue reimbursement directly from the insurance company.

_____ _____
Signature of Patient Date

_____ _____
Signature of Guarantor (If patient is a minor/indigent) Date