Terms of Agreement

Please INITIAL after each term of agreement.

_____ The Hand Center of San Antonio has the right to release confidential medical information to other parties involved in my care including my insurance carrier, my referring physician and/or my primary physician.

_____ If my insurance requires a referral and I do not obtain one in advance of my appointment, I will be required to make payment in full or reschedule my appointment.

_____ I understand an agree that I am financially responsible for all in-network and/or out of network balances owed to The Hand Center of San Antonio as assigned by my insurance carrier.

_____ I understand and agree that a deposit may be required 3 days prior to scheduled surgery.

_____ I understand copay, coinsurance, and deductibles are due at the time of service.

_____ I understand the charges incurred are not final until the chart has been reviewed and the billing process is completed.

Acknowledge of Receipt of Notice of Privacy Practices

I acknowledge that I have been given an opportunity to review the Notice of Privacy Practices from The Hand Center of San Antonio and that I may request a copy for my records if I so choose.

____ _________________________

Signature of Patient or Legal Representative Date

____ _________________________

Print Name of Patient or Legal Representative Date

Acknowledgement and Authorization to Treat

I, ___________________________ Legal Guardian/Parent/Self, authorize medical treatment by a staff physician associated with, The Hand Center of San Antonio.

____ _________________________

Patient or Legal Representative Signature Date

____ ________________ ___________________

Responsible Party Name DOB SS#

(Office use Only)

_____________________ ___________________ ____________________

Reviewed by Date Patient #/Doctor#