

**Prairie Orthopaedic & Plastic Surgery, PC (POPS)**  
**Financial Policy, Statement of Responsibility and Other Acknowledgements**

**Insurance filing:** You are responsible for verifying if providers are in-network with your insurance company. We will submit medical claims to your insurance company. Your insurance policy is a contract between you and your insurance company. **Deductibles, Coinsurance and Co-Payment amounts are established by your health insurance plan and are due at the time of service.** Any remaining balance after the processing of the claim is the patient's responsibility.

**Surgery:** Arrangements will need to be made to meet your financial responsibilities prior to your surgery. Our financial/surgery coordinator will verify your eligibility and benefits with your insurance plan. **A prepayment of the estimated out-of-pocket expenses, as specified by your insurance plan, will be required one week prior to your surgery.** Should you cancel or reschedule your surgery; a cancellation fee may apply.

**Liability and Auto Accidents:** We will file any insurance claims for services related to an auto or third party liability. Additionally, we may be required to submit claims to your health insurance and will need your insurance information prior to treatment. **Patients who fail to provide insurance information are directly responsible for payment of their account.** By signing below you agree to assign all benefit dollars to POPS for services provided.

**Worker's Compensation:** If your injury is work-related, we will need the case number, carrier name and information prior to your visit in order to bill the worker's compensation insurance company or your employer. The patient is ultimately responsible for all professional fees if a worker's compensation claim is denied.

**Liens:** Liens may be placed on accounts related to auto accidents, liability or denied worker's compensation with attorney coverage. The lien will be placed on the person causing the accident, the patient's attorney, the patient, the attorney of the person causing the injury (if known) and the insurance company. We **MAY** choose to not accept health insurance payments or take contractual adjustments unless required to do so by your personal health insurance carrier.

**Self Pay Accounts: Payment is due at the time of service.** If surgery is recommended, we expect payment in full one week prior to the procedure.

**Forms: There will be a charge for the completion of medical forms filled out by your provider and/or staff, \$20/Disability forms.** Please allow 7-10 days for the completion of these forms. If you would like the forms mailed to you or your insurance company, payment will be due prior to mailing of the forms.

**Divorce:** The parent signing this Financial Policy and Statement of Responsibility is responsible for any and all payments for services. Any legal agreement, or other disagreement, between two parties in a divorce must be dealt with between those parties and does not involve POPS.

**Medical Records:** POPS may transfer copies of your medical record, or portions thereof, to you or a third party, including but not limited to your personal representative, your health insurance carrier, attorneys, physicians involved with your care, your workers compensation carrier, and/or liability carriers. **The minimum charge to copy records is \$0.50 per page plus a handling fee and any applicable sales tax.**

**Payment:** WE ACCEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER AND CARE CREDIT. Interest at 18% APR will be charged on balances 60 days or older. If your check is returned due to insufficient funds, a **\$30 returned check fee** will be added to your account balance. An account representative can be reached at **402-489-4700**.

**Delinquency:** Accounts will be considered delinquent if not paid in full within 60 days of initial billing or if acceptable payment arrangements have not been made and will be considered for collection or legal action. In the event of nonpayment, you are responsible to pay the cost of collection and/or court costs and reasonable fees should they be required.

**Medical Consent:** By signing below you hereby request and consent to medical care including all examinations, tests, and other procedures which the health care providers of Prairie Orthopaedic & Plastic Surgery, PC and such assistants and staff may deem necessary or appropriate. You are aware that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to you as a result of treatment or procedures performed. In addition, you consent to prescription history and/or narcotic history reconciliation by your provider via the electronic history provided through Surescripts and/or the state controlled substances database.

**Consent to Contact:** By signing below you hereby consent to receive communications from POPS staff or contractors, including collection agents to any landline, cell number, or email address provided. This information may be used to contact you live, via voicemail, text, email, by pre-recorded message, or auto-dialer in regards to appointments, treatment, marketed services or billing/collection services.

**AI Scribe Tool:** I understand that my healthcare provider may use an AI-powered documentation tool (AI Scribe) to create clinical notes during our visits. This tool records and transcribes our conversation to allow the provider to focus on my care. **Privacy & Security:** I understand that all recordings are processed in compliance with HIPAA and relevant privacy laws, ensuring my data is secure. **Data Usage:** The AI tool only accesses our conversation during this session to assist with documentation, and the content is reviewed for accuracy by my provider. **Voluntary Participation:** My participation is voluntary, and I can ask the provider to turn off the AI scribe at any time without impacting my care.

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**Detailed Payment Information**

**Office Visits:** Office charges will be determined by your physician following your exam today. Office charges may include: initial exam, x-rays, injections, fracture care with casting, and any supplies. Upon completion of your visit, staff will work with you to determine your portion of the bill which is payable today.

**Global Periods or Fracture Care:** Any patient that undergoes a surgical procedure or is in a fracture care category will be billed using a global period. This means that for 10 or 90 days (dependent on procedure) following your surgery all follow-up care with the physician is already covered. This does **not** include further needed x-rays, supplies, therapy or injections.

**Surgery:** Since you (or your employer) have chosen an insurance carrier with particular benefits and because insurance coverage is a complicated business with no fixed rules, please check with your insurance carrier in regard to the specifics of your proposed surgery. Also, please note that any non-POPS hospital bill is not something we can control, so please direct any questions regarding the specifics of the hospital, lab and anesthesia bill to the hospital billing office where your surgery was or will be performed.

Many surgical procedures can be complex and require a trained surgical team. Dr. Hurlbut, Dr. Machado, Dr. Byington, Dr. Krejci-Reed, Dr. Ternent and Dr. Dodson work with fully trained physician assistants who assist them during the operation. You will receive a bill for their services as well.

Our Financial or Surgery Coordinator will verify your eligibility and benefits and work with you to determine your out-of-pocket expense for your particular surgery. Financial arrangements will need to be made to meet your financial responsibilities prior to your surgery.

**Frequently Asked Questions**

**What is a co-pay?** Typically, the co-pay is a set amount the consumer will pay to see a physician. For example, an office visit to your physician might have a co-pay of \$30; Dr. Hurlbut, Dr. Machado, Dr. Krejci and Dr. Byington are physician specialists so therefore your specialist co-pay would apply to your visit here, e.g., \$60. Your carrier requires that all co-pays be paid prior to any services being rendered. This co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier.

**What is co-insurance?** Co-insurance is a percentage of the allowed cost either the insurance or consumer will pay. For example an 80/20 plan typically represents that the insurance will pay 80% of the allowed cost and the consumer is responsible for the remaining 20% of the allowed cost, after the consumer's deductible has been paid.

**What is a deductible?** A deductible is an annual dollar amount established by your insurance plan the consumer must pay before insurance benefits are applied. This amount is your obligation and must be paid prior to having surgery.

**What are out of-pocket expenses?** All expenses not covered by insurance that you are responsible for paying for via cash, check, credit or debit.

**ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY RIGHTS AND PRACTICES  
PRAIRIE ORTHOPAEDIC & PLASTIC SURGERY**

I acknowledge that I have been provided access to the Prairie Orthopaedic & Plastic Surgery (POPS), Notice of Privacy Rights and Practices, effective August 23, 2018, which explains how my health information will be handled in various situations. I understand that POPS reserves the right to change the Notice and its Privacy practices at any time. This document in its entirety is available by request, located in the waiting area, or online at [www.prairie-ortho.com](http://www.prairie-ortho.com).

\_\_\_\_\_  
Patient's/Patient's Representative Signature

\_\_\_\_\_  
Date

**DISCLOSURE OF PHYSICIAN OWNERSHIP - LINCOLN SURGICAL HOSPITAL**

Lincoln Surgical Hospital (LSH) meets the definition of "physician-owned" under 42 CFR 489.3. Dr. Patrick Hurlbut, Dr. Gustavo Machado, Dr. Kara Krejci, and Dr. Matthew Byington have a small financial interest in this facility. You have the right to choose the provider of your health care services. Although we believe the LSH will be able to meet your surgical needs, if necessary, you have the option to use a facility other than LSH. You will not be treated differently by your physician if you choose to use a different facility; however, your physician may not be able to perform your procedures at an alternative facility if he does not maintain privileges at such a facility. If desired, your physician or a staff member can provide information about alternative health care options.

**DISCLOSURE OF PHYSICIAN OWNERSHIP - PRAIRIE ORTHOPAEDIC & PLASTIC SURGERY THERAPY**

Prairie Orthopaedic & Plastic Surgery Physical Therapy is a physician-owned rehabilitation facility. Dr. Hurlbut & Dr. Machado have a financial interest in this facility. You have the right to choose the provider of your health care services, including your Physical Therapist. Although we believe that Prairie Orthopaedic & Plastic Surgery Physical Therapy will be able to meet your therapy needs, if necessary, you have the option to use a facility or therapist of your choice. You will not be treated differently by your physician if you choose a different facility. If desired, your physician or a staff member can provide information about alternative options.

**DISCLOSURE OF PHYSICIAN OWNERSHIP - DOCTORS OUTPATIENT SURGERY CENTER**

Doctors Outpatient Surgery Center is a physician owned facility in Lincoln, NE. Dr. Patrick Hurlbut, Dr. Gustavo Machado, and Dr. Kara Krejci are partners in the ownership of this facility. You have the right to choose the provider of your health care services. You also have the right to choose the facility at which you receive those health care services. You will not be treated differently by your physician if you choose to use a different facility; however, your physician may not be able to perform your procedures at an alternative facility if he/she does not maintain privileges at such a facility. If desired, your physician or a staff member can provide information about alternative health care options.

By signing this document, you acknowledge that you have read and understand the foregoing notice to patient regarding the HIPAA Privacy Rights and Practices and Physician Ownership Policy of POPS.

\_\_\_\_\_  
Patient's/Patient's Representative Signature

\_\_\_\_\_  
Date

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**(To be completed by POPS staff should Acknowledgement Form not be signed)**

Does patient have a copy of the Privacy Notice?  Yes  No

Please explain why the patient was unable to sign form and POPS efforts in trying to obtain signature:

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\_\_\_\_\_

**Prairie Orthopaedic & Plastic Surgery, PC (POPS)**  
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**Assignment of Benefits:** I have read and agree to the terms and conditions on the financial policy and I hereby authorize the release of any medical information necessary to process my health insurance claim. I assign all benefit proceeds for services rendered by POPS including health insurance, worker's compensation, third party liability, and other benefit proceeds and request payment of benefits to the provider of services. I understand I am financially responsible to POPS for charges not covered or denied by my insurance company.

**Financial Agreement:** I hereby certify that I have read, understand, and agree to the information set forth above.

**Medical Consent to Treat:** I understand by signing this form, I am authorizing POPS to provide treatment for as long as I seek care from Prairie Orthopaedic & Plastic Surgery, PC, or until I withdraw my consent in writing.

**Physical Therapy Consent to Treat:** I understand by signing this form, and should I choose POPS Physical Therapy for my care, I am authorizing POPS Physical Therapy to provide treatment for as long as I seek care from Prairie Orthopaedic & Plastic Surgery, PC, or until I withdraw my consent in writing.

The undersigned certifies that he or she has read the foregoing, is the patient or Responsible Party duly authorized by and on behalf of the patient to execute this document and accept its terms.

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Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

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Responsible Party's Signature \_\_\_\_\_

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For Office Use Only:

Patient was unable to sign consent because: \_\_\_\_\_

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Witness \_\_\_\_\_ Date \_\_\_\_\_