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Billing the Patient

Purpose:

This is a professional office that renders quality care to patients. Our duty is to preserve the dignity and confidentiality of our patients while receiving appropriate payment for the medical care we have provided. The following details this practice's policies and procedures regarding patient billing. The following policies comply with the provisions of Texas Occupations Code Chapter 101.

Policy:

Office Visit

Payment is expected at the time of service unless arrangements have been made prior to treatment.

The office will file insurance claims for services rendered, but patients are not relieved of responsibility for payment because they have insurance unless a contract prohibits billing the patient, such as a contract between this practice and a HMO.

Patients must pay copays or deductibles before surgical procedures are performed and at the time that office services are rendered, absent an insurance carrier contract provision to the contrary.

Most HMO and PPO patients have copayments, deductibles, or coinsurance. Our practice is obligated to provide medically necessary services to patients as required by the standard of care set by the profession and contracts with insurance carriers. We also must be mindful that in many cases, we cannot bill the patient for amounts left unpaid by carriers when we have a contract with the patient's insurance carrier. Our office keeps its agreements and will not bill or charge patients when our contracts do not permit it. Complaints related to billed charges shall be directed to the billing compliance officer for resolution.

When Patients Are Billed

Our office will honor any request a patient makes to use an alternative billing address, but any patient making such a request must provide a suitable alternative for billing purposes in writing.

After we receive payment from the insurance company, this office will reconcile the explanation of payment, then bill the patient for the unpaid amount unless a contract with an insurance carrier prohibits it.

Any claim denied due to patient ineligibility should be billed directly to the patient.

Patients are billed (when an insurance carrier contract does not prevent billing) when a claim is denied due to benefit limits, services are not covered, or when there is still a patient responsibility balance on the account.

Mailing Statements

Our billing office will send patients a statement of their bill no more than 30 days after the date of service.

Our billing office will then send the second statement 60 days after the date of service.

Past Due Accounts

If the patient has not settled his or her account by the 75th day following the date of service, our office will attempt to contact the patient to request payment.

The third statement will be sent 90 days after the date of service.

If a patient does not make payment by the 110th day, a letter will be sent to the patient stating that unless payment is received in 10 days, the practice will turn the account over to an outside collection agency.