THE STERNBERG CLINIC
surgeons who listen

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Our Office and Financial Policies

Patient Name___________________________ Date: ___________________

If patient is under age 18, this form must be initialed and signed by a parent or guardian.

_______Please check if patient is a minor.

Thank you for choosing to be a patient of **The Sternberg Clinic (TSC)**. We appreciate your confidence in our services and expert care. Our primary intention is to take the best possible care of you and ensure that you have an excellent outcome. In order to do that, we must inform you of our office policies and certain insurance issues that may affect your out-of-pocket costs and financial responsibilities. Please initial each section to confirm your understanding. If you are unable to agree to our policies, it may limit our ability to care for you.

Insurance: We will bill your insurance company/companies as a courtesy; however, you are responsible for all charges not covered by your medical insurance, including but not limited to copayments, deductibles, co-insurances, and non-covered services.

Notice of a change in our Insurance Contracts

As of May 1st, 2021, Dr. Sternberg will no longer be contracted with commercial insurance companies. Another term for this is that he will be an Out-of-Network provider. He will remain contracted with Medicare. We are not contracted with Medicaid/Medi-Cal and if you have such insurance, you may be required to get your care from physicians contracted with Medicaid/Medi-Cal.
___________________PLEASE INITIAL

What does out-of-network or non-participating mean?

Out-of-network means that a physician does not have a contract with your health insurance plan. This can sometimes result in higher costs for you to have care with Dr. Sternberg. **PLEASE DON'T PANIC!** Our rates are actually reasonable and most PPO insurance plans do have out of network coverage and many have excellent out-of-

network benefits. Some health plans, such as HMO plans, may not cover care from out-of-network providers. There are exceptions, however, and you would need to contact your insurance provider to see if they would grant special permission (called a letter of understanding, LOA).

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Why does in-network vs. out-of-network matter?

If you have a PPO plan, you may have coverage for out-of-network care wherever you choose, but your out-of-pocket cost for out-of-network health care may be higher than care in-network. Many patients with PPO plans actually have good or excellent out-of-network benefits which may cover the majority or all of the surgical costs. Also, while Dr. Sternberg will no longer be contracted with your insurance company, the ambulatory surgery center where he operates (The Presidio Surgery Center) is likely contracted and the anesthesiologists who work there are as well, so their charges should be covered on the in-network portion of your plan.

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We provide certain unique services:

Since Dr. Sternberg provides certain unique services, you likely will not be able to find similar treatment options with an in-network surgeon. In some cases, you can petition your insurance carrier to sign a letter of understanding (LOA) with Dr. Sternberg to cover the cost of care. They would have to agree to our terms of payment.

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We take care of all the insurance paperwork and billing for you:

Our goal is to take care of everyone who we can and as a courtesy for you we will bill your insurance carrier for the cost of Dr. Sternberg's care on your behalf.

Costs for You:

While we certainly hope that your insurance provider pays the full cost of our surgical fee (they will pay the in-network coverage, anesthesia fees and surgery center costs, after you meet your deductible) they may not. So, we do need you to submit a deposit before the date of your surgery.

The charge for our professional component of pilonidal surgery to your insurance carrier is $10,000-$15,000+, depending upon the complexity of your operation. However, **the maximum amount that we will ever charge you for pilonidal surgery is $5,300.00** (other procedures have different fees). We ask that you pay a 50% deposit, or $2,650, (other amounts for other operations) before the day of surgery. If you have a financial hardship, we understand and can arrange a payment plan.

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Your out-of-pocket costs for Dr. Sternberg's surgical fee will never exceed $5,300 (or the quoted amount for other operations) and may be less if your insurance provider has good out-of-network benefits. ______________**PLEASE INITIAL**

Understanding billing for Surgery:

Understand that Dr. Sternberg's professional fee is 1 of 3 separate bills that you may receive, the other 2 being from the anesthesiology group (NCAP) and the other being from the facility (The Presidio Surgery Center). If there's an issue with either of the latter 2 entity's bills, please contact them directly as we do not have control over their billing. ___________**PLEASE INITIAL**

Your insurance provider may pay you for Dr. Sternberg's surgical fee (Assignment of Benefits):

Since we do not have a contract with your insurance provider, your insurance provider will likely send all payments to you and expect you to pay The Sternberg Clinic. In the event that your insurance provider does send you a check for Dr Sternberg's surgical fee, these payments are intended for The Sternberg Clinic. By signing below, you are authorizing payments of medical benefits from your insurance company to be directly assigned to The Sternberg Clinic for services rendered. In the event that payments for such services are still sent to you, for your convenience, we require that you leave an encrypted **credit card on file** with us to make this money transfer seamless and effortless for you. As a courtesy, we will charge your credit card for the balance of our surgical fee 45 days after surgery.

Regardless of the amount your insurance has decided to send you for Dr. Sternberg's services, **you will never be required to pay us out of your pocket greater than the $5,300 and you will only be required to pay $5,300 if your insurance does not cover any of Dr. Sternberg's surgical fee.** You will be responsible for the original deposit of $2,650 and you will be responsible for the remaining balance of $2,650 to be paid 45 days after surgery. **If your plan, however, pays you more than $5,300, you will owe nothing more than your initial deposit** once we have been paid the balance plus what the plan paid over $5,300.

Each surgery is different, and some are more complicated than others. This is where the health plan may pay greater than the $5,300. In this case any amount over $5,300 is due to the practice. ______________**PLEASE INITIAL**

Workman's Compensation:

Please note that we do not accept **workman's compensation cases**.
______________**PLEASE INITIAL**

Other Fees:

Post-Operative visits: no charge during first 90 days
Cost of Consultation (inclusive if an office procedure is performed): $300
Cost of follow-up visits (inclusive if an office procedure is performed): $150

Additional Cost if a procedure is performed at the time of a consultation or follow-up visit such as I&D or hemorrhoid treatment: $100
We are happy to provide other procedural costs on request such as anal fistula surgery, hemorrhoidectomy, lipoma removal, or removal of anal warts

Our Surgery Cancelation Policy:

Our services are in demand and patients often wait a month or 2 for their surgery. Late cancelations deprive other patients the opportunity to undergo needed surgery. Due to the increasing costs of last-minute cancelled surgeries, we have had to institute a **surgery cancellation policy**. If you need to cancel a scheduled surgical procedure, we request that you do so well in advance. If you must cancel within **10 business days** of the planned operation, we will charge your credit card $500. That means, if you have surgery scheduled for a Wednesday, and you want to cancel, you must do so by 5 PM 2 Wednesdays before. Patients who cancel surgery within **5 business days** (for a Wednesday Surgery, canceling after 5 PM the Wednesdays before or after) will be charged $1,000. Surgery cancelations within several days of a scheduled operation don't allow time to add other patients in your place and impact other patients in need of surgery, the surgery center, the nurses who work there, the anesthesiologists, and our practice. ___________________ **PLEASE INITIAL – please note that these charges are far below costs.**

Notice of Financial Interest: California Business and Professions Code Section 654.2 require that The Sternberg Clinic disclose that Dr. Sternberg has a financial interest in the **Presidio Surgery Center**. You may choose to have your procedures or surgery at a site in which we do not have a financial interest. ___________________ **PLEASE INITIAL**

Tracking Surgical Outcomes and Communications from TSC:

Dr. Sternberg is sincerely interested in the outcome of his patients. We will periodically contact you by **email, phone, or text message** in order to check in with you and learn how you are doing. Please respond so that we know how you are doing. We will make this process as easy and hassle free as possible. You will likely just need to respond with a one word or number response. Of course, if you would like to tell us more you will be able to, and we will always respond if you have any questions.
__________________ **BY INITIALING, YOU ARE ALLOWING US TO CONTACT YOU BY PHONE, EMAIL, OR TEXT MESSAGE.**

Notice of Privacy Practices:

All of our employees, managers, and physicians are trained to understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**). We strive to achieve the highest standard of ethics and integrity in performing services for our patients. It is our policy to determine uses of Personal Health Information in accordance with government rules, laws and regulations.

If you have any questions in reference to this form, please contact us at 415-417-3377.
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Dr. Sternberg may release medical information or speak to the following persons on your behalf with regards to your medical condition:

Person__________________________
Relation_____________________________________

Person__________________________
Relation_____________________________________

Person__________________________
Relation_____________________________________

We are looking forward to partnering with you on your journey to getting better,
Dr. Sternberg and the staff at the Sternberg Clinic

Your signature below attests that you have read and understand our office and financial policies:

Sign_________________________________

print_________________________________ Patient/Representative