THE STERNBERG CLINIC
surgeons who listen

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Our Office and Financial Policies

Updated 09.21

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. 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 is no longer 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 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).

_____ **PLEASE INITIAL**

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 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.

_____ **PLEASE INITIAL**

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.

_____ **PLEASE INITIAL**

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, depending on your out of network benefits, we may ask you to pay 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). If you have a financial hardship, we understand and can arrange a payment plan. Please alert us if this applies.

_____**PLEASE INITIAL**

Your out-of-pocket costs for Dr. Sternberg's surgical fee will never exceed $5,300 (or the quoted amount for other operations) for the surgery and may be less if your insurance provider has good out-of-network benefits. There is a $300 charge for the initial consultation which will be waived if you pay the entire surgical cost upfront.
_____**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 (Anesthesia Care Associates Medical Group) and the other being from the facility (The Presidio Surgery Center). If there is 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 may send payments to you and expect you to pay The Sternberg Clinic. If 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 agreeing to send The Sternberg Clinic any monies sent to you by the insurance company (or allowing The Sternberg Clinic to charge your credit card for reimbursement).

Regardless of the amount your insurance has decided to send you for Dr. Sternberg's services, **you will never be required to pay us more than $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. If your plan, however, pays any amount, it will reduce the amount that you owe.**

Important:

Please be aware: since our charges to the insurance company will likely be higher than our charge of $5,300 to you, you may receive an initial large bill reflecting the amount billed to your insurance company ($15,000 or more) as these billings are automated. If you receive such a bill, it indicates that your insurance company has not yet processed the surgery claim. PLEASE DO NOT PANIC! You are not expected to pay this bill and <u>you do not need to call us</u>. You are certainly welcome to prod your insurance company to process the claim. If you are required to pay us anything more or reimburse us for the monies that your insurer paid you, we will call you, and you will never be required to pay anything more than $5,300.
_____**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 more 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 cancelation 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 you $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 do not 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 about this form, please contact us at 415-417-3377. _____ **PLEASE INITIAL**

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