

The Orthopedic Institute of North Texas, P.A.  
Baylor Scott & White Frisco – Physician Office Building 1  
5575 Warren Parkway, Suite 115  
Frisco TX, 75034

**Advanced Beneficiary Notice of Noncoverage (ABN)**

The Orthopedic Institute of North Texas, P.A. employs mid-level providers (i.e. Physician Assistants, First Assistants) in the operating room to help with your surgery. While your doctor will perform the integral parts of your surgery, there is a need to have a second person present at the time of your surgery in order to provide assistance due to the complex nature of surgery.

**NOTE:** If your insurance doesn't pay for an operating assistant, you will be financially responsible for payment for the assistant. We understand the expense associated with surgery and will make every effort to limit the costs incurred by you. If the claim is denied, **a flat rate of \$300.00** will become your responsibility prior to the surgical procedure.

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to allow an assistant to be present at the time of your surgery  
**Note:** If you choose option 1, we will bill your insurance company and apply any payment to the rate described. You will still be responsible if it is less than the flat rate of \$300.00.

OPTIONS: Check only one box. We cannot choose a box for you.

**OPTION 1.** I want an assistant to help my surgeon perform my surgery. I understand I may be asked to pay the \$300.00 now but I may receive that back after the insurance company approves the payment for the assistant fee. If the assistant fee is not approved, there will be no reimbursement to me. If there is partial reimbursement, I may receive part of the \$300.00 back after the insurance company remits payment to the Orthopedic Institute of North Texas.

**OPTION 2.** I do not want an assistant to help my surgeon perform my surgery. I understand with this choice I am **not** responsible for payment, and that **I cannot appeal to see if my insurance will pay for an assistant.**

**Additional Information:**

This notice gives you the information regarding the option of choosing a surgical assistant to help perform your surgery. If you have other questions regarding the use of an assistant, **please do not hesitate to discuss your surgery with your surgeon.**

Signing below means that you have received and understand this notice. You may also request a copy for your records.

Signature:	Date:
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