Network Participation Notice

DFW Center for Spinal Disorders is a participating partner with most major health insurance carriers and many of the smaller area plans as well. If you have questions about the services you will receive or your out of pocket responsibility, please speak with a member of our team prior to your appointment.

In order to provide the best care possible, our office may need to refer you outside of the practice for additional attention. Services that our providers may recommend include advanced imaging, physical therapy, pain management, intraoperative services, and home health care. While our practice makes a great effort to work with companies that are partnered with many major health insurance carriers, some health care professionals may not be participating with the same insurance plans and networks as DFW Center for Spinal Disorders. This means the doctor or provider may not have a contract with your plan. Additionally, you may receive a separate invoice for any service not provided by DFW Center for Spinal Disorders.

Our practice makes a great effort to ensure that we work with groups who maintain fair and accurate billing practices. In Texas, a healthcare provider is required notify a patient if they intend to balance bill for any services that are out of network. The term “balance billing” refers to the process of billing a patient for the difference between the charged amount and any amounts paid by the patient’s insurer or applied to a patient’s deductible, coinsurance, or copay. Thus, while you may receive an invoice for the copay/coinsurance determined by your benefit plan, as required by law, you should not receive a balance bill for services rendered unless you have first agreed to such invoicing in writing.

Please note that if you have out-of-network benefits under the terms of your benefit plan, you may utilize those benefits to receive services from a non-participating provider. If you do not have out-of-network benefits under the terms of your benefit plan and you receive services from a non-participating provider, you may be responsible for the cost of the services.

I am aware that I may be referred for services not provided by DFW Center for Spinal Disorders and that these services may not be covered by my insurance plan.

Patient Name: _____ DOB:_____

Signature: _____ Date:_____