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| --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION** |  | | | | |
| Patient Name: (First) |  | (Middle) |  |  | (Last) |
| Social Security Number: |  | Age: | Date of Birth: |  | Sex:  Male Female |

 DEMOGRAPHICS PAPERWORK

**NEW PATIENT PACKET**

Welcome and thank you for selecting Integrity Spine & Orthopedics. We strive to provide our patients with the best possible care and service. Please fill out this form completely and let us know if you have any questions or need assistance.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Address: |  | | | | | |
| City: |  | State: |  | Zip code: | |  |
| Home Phone: |  | Cell Phone: |  | Work Phone: | |  |
| Email Address: |  |  |  |  | | |
| Are we permitted to contact you at the phone numbers (including, without limitation, through text messaging) and/or e-mail address listed above regarding appointment reminders, waiting lists, and missed appointments? |  |  |  | Contact preference:  Email Phone | | |
| Yes No |  |  |  |  | | |
| Employer: |  | Occupation: |  |  | | |
| Address: |  |  |  |  | | |
| City: |  | State: |  | Zip code: | | |
| Marital Status:  Single Married Divorced |  | Widowed |  | Other: | | |
| Emergency Contact: |  |  |  | Phone: |  | |
| Relationship to Patient: |  |  |  |  |  | |
| Primary Care Physician: |  |  |  | Phone: |  | |
| Address: |  |  |  |  |  | |
| City: |  | State: |  | Zip code: |  | |

# POLICIES, AUTHORIZATIONS, AND AGREEMENTS

### APPOINTMENTS

To schedule an appointment, please call our office as early in advance as possible. We recognize that everyone’s time is valuable, so we make every effort to maintain the scheduled appointment times, but urgent situations sometimes disrupt the schedule. We ask for your understanding and patience during any delay. We will make every effort to keep your waiting time to a minimum. If you are unable to keep your appointment, please call. Late arrival may necessitate rescheduling your appointment.

### EMERGENCIES & AFTER-HOUR CALLS

If experiencing a medical emergency or life-threatening situation, call 911 immediately or go to the emergency department of the nearest hospital. When the office is closed, telephone calls will be relayed to our answering service. The answering service will ask your name, telephone number, and the reason for your call. This information will be relayed to the health care provider on call. For routine questions and prescriptions refill requests, we ask that you please call the office during the next business day.

### PRESCRIPTION REQUESTS

Our office issues non-emergency prescriptions during weekday office hours only. To submit a request, please call the office and provide us with the prescription name, dosage quantity of medication, when you take it and how, and how many refills you usually receive. If our office is able to call in the prescription, you will need to provide us with the name and location of the pharmacy. Your health care provider may require you to make an appointment in order to receive refills or if there are any questions or concerns regarding your medications.

### FINANCIAL POLICY & AGREEMENT

I understand and agree that in consideration of the services provided, unless otherwise mutually agreed, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered by Integrity Spine & Orthopedics. I am responsible for any applicable deductible, copayments, or coinsurance prior to the provision of services. I further understand that, unless otherwise mutually agreed, such payment responsibility is not contingent on any insurance, settlement or judgment payment. Integrity Spine & Orthopedics may file a claim for payment with my insurance company as a courtesy to me. If the insurance company fails to pay Integrity Spine & Orthopedics in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Integrity Spine & Orthopedics.

I understand and agree that payment may be made to Integrity Spine & Orthopedics in the form of cash, check, debit cards, and credit cards. In the event that I receive a check directly from my insurance company payable to me for services rendered by Integrity Spine & Orthopedics, I understand that this payment belongs to Integrity Spine & Orthopedics. I agree to endorse the back of the check to be payable to "Integrity Spine & Orthopedics, LLC" and to promptly deliver the check to Integrity Spine & Orthopedics.

I understand that patient credits are applied to outstanding patient balances prior to the issuance of any refunds. I understand additional charges will be applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. I agree that I may be charged a late cancellation fee if I do not cancel my scheduled appointment at least two (2) business days in advance.

Should my account be referred to a collection agency or attorney for collection, I will pay all costs of collection, including reasonable attorney fees. I understand balances not paid in full or payment arrangements not scheduled within 60 days of the initial statement are considered delinquent. I understand that patients who do not pay their outstanding bills within 90 days of the initial statement may be discharged from Integrity Spine & Orthopedics.

I understand that it is my responsibility to provide Integrity Spine & Orthopedics with a copy of my current insurance card. If I do not have health insurance, choose not to use my health insurance, and/or otherwise fail to notify Integrity Spine & Orthopedics of my health insurance coverage, I understand and agree that, unless otherwise mutually agreed, I will be financially responsible for the total amount of the services provided. I will notify Integrity Spine & Orthopedics immediately upon any change in my insurance. I understand that, unless otherwise mutually agreed, I am financially responsible for all charges not covered by insurance. I certify that the information provided by me in applying for payment under my insurance plan(s) is correct. I understand that if any service is not covered under my insurance plan (“Non-Covered Services”), I must pay for such Non-Covered Services.

### CONSENT TO TREATMENT & PROFESSIONAL SERVICES

I hereby consent to, and authorize, the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my health care providers may be considered necessary or advisable for my diagnosis and/or treatment. This care may include, but is not limited to, diagnostic, radiology and laboratory procedures, administration of drugs, biological and other therapeutics and medical and nursing care.

### ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services, products, and/or procedures rendered directly to Integrity Spine & Orthopedics. I understand that, unless otherwise mutually agreed, I am financially responsible for all charges not covered by insurance. I certify that the information provided by me in applying for payment under Medicare or insurance plan(s) is correct and I hereby request all authorized benefits. I hereby authorize and instruct my insurance carrier to make payment directly to Integrity Spine & Orthopedics for benefits and payments otherwise payable to me. Unless otherwise mutually agreed, I agree to personally pay for any charges that are not covered by, or collected from, any insurance program, including any deductibles, coinsurance, and copayment amounts.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ OR HAD READ TO ME, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS, AND THAT I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ANSWERED. TO THE EXTENT THAT I AM A DIFFERENT INDIVIDUAL THAN THE PATIENT IDENTIFIED HEREIN, I REPRESENT AND WARRANT THAT I AM FULLY AUTHORIZED TO REPRESENT THE PATIENT AND EXECUTE THIS AGREEMENT ON BEHALF OF THE PATIENT.

|  |  |  |
| --- | --- | --- |
| **Patient Name (Print):** |  | **Patient** **Representative** **Name** (**Print** if A**pplicable**): |
| **Signature of Patient or Representative:** |  | **Representative's Relationship to Patient (Print if Applicable):** |
| **Date:** |  |  |

**NOTICE OF PRIVACY PRACTICES & PATIENT RIGHTS AND RESPONSIBILITIES**

### ACKNOWLEDGMENT FORM

I have received a copy of the Integrity Spine & Orthopedics' Notice of Privacy Practices (the “Notice”) and understand that the Notice describes certain rights I have under applicable laws and discusses how my medical information may be used by Integrity Spine & Orthopedics. I have been given an opportunity to ask questions about the Notice. I acknowledge and agree that Integrity Spine & Orthopedics the right to revise this Notice at any time and will post a copy of the current Notice on their website at all times. Integrity Spine & Orthopedics will provide me with a copy of its most recent Notice upon my request.

|  |  |  |
| --- | --- | --- |
| **Patient Name (Print):** |  | **Patient** **Representative** **Name** (**Print** if A**pplicable**): |
| **Signature of Patient or Representative:** |  | **Representative's Relationship to Patient (Print if Applicable):** |
| **Date:** |  |  |

Please list the names of people we may communicate with regarding your medical care:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

### PATIENT RIGHTS AND RESPONSIBILITIES

I have received a copy of the Patient Rights and Responsibilities notice and understand the notice describes patient rights as well as patient responsibilities. I have been given the opportunity to ask questions about the Patient Rights and Responsibilities.

|  |  |  |
| --- | --- | --- |
| **Patient Name (Print):** |  | **Patient** **Representative** **Name** (**Print** if A**pplicable**): |
| **Signature of Patient or Representative:** |  | **Representative's Relationship to Patient (Print if Applicable):** |
| **Date:** |  |  |

# AUTHORIZATION TO RELEASE INFORMATION

### AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical or other information to any entity or government agency necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided by Integrity Spine & Orthopedics. A copy of this authorization may be sent to any entity or government agency if requested. The original authorization will be kept on file by Integrity Spine & Orthopedics.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient Name (Print):** |  | **SSN:** | |  | **Date of Birth:** |
| **Signature of Patient of Representative:** |  |  |  | |  |
| **Patient** **Representative** **Name** (**Print** if A**pplicable**): |  |  |  | |  |
| **Representative's Relationship to Patient:** |  | **Date:** | | | |

# MEDICAL RECORDS REQUEST AUTHORIZATION

To:

Phone: Fax:

I, give full authorization to release to the physicians and other health care providers of Integrity Spine & Orthopedics for purposes of diagnosing and treating my condition(s). If you have any questions, please feel free to contact me at the number listed above.

Thank you,

|  |  |  |
| --- | --- | --- |
| Phone Number: |  | Date of Birth: |
| Contact Person: |  |  |
| Patient Name (Print): |  | Patient Representative Name (Print if Applicable): |
| Signature of Patient or Representative: |  | Representative's Relationship to Patient (Print if Applicable): |
| Date: |  |  |

**PATIENT ACKNOWLEDGEMENT: HEALTH INSURANCE**

COMPLETE THIS FORM **ONLY IF** YOU DO NOT HAVE HEALTH INSURANCE OR

ARE CHOOSING NOT TO USE YOUR HEALTH INSURANCE FOR YOUR CARE.

Patient name:

I understand that Integrity Spine & Orthopedics will not be filing a claim to any health insurance company for services rendered either because I do not have health insurance or because I am choosing not to use my health insurance for my care. In the event that I am a third-party beneficiary under a contract between Integrity Spine & Orthopedics and my health insurance carrier, I hereby voluntarily and intentionally waive and relinquish my privileges and advantages as a third-party beneficiary under that contract.

To the extent that I am a different individual than the patient identified herein (if applicable), I represent and warrant that I am fully authorized to represent the patient and execute this agreement on behalf of the patient.

I fully understand that notwithstanding any provisions herein, I am directly and fully responsible to Integrity Spine & Orthopedics for all bills for services rendered, and that this agreement is made solely for the additional financial protection of Integrity Spine & Orthopedics. I agree to hold Integrity Spine & Orthopedics and all of its providers, members, managers, officers, directors, employees, and agents harmless from and against any claims, losses, or damages, including, but not limited to attorneys’ fees, that arise as a result of me submitting a claim to insurance for such services or otherwise not abiding by the terms of this document.

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name (Print):** |  | | **Patient** **Representative** **Name** (**Print** if A**pplicable**): |
| **Signature of Patient or Representative:** | |  | **Representative's Relationship to Patient (Print if Applicable):** | |