INTEGRITY
SPINE & ORTHOPEDICS

# NP 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.

## PATIENT INFORMATION

Patient Name: (First) ____________ (Middle) ____________ (Last) ____________

Social Security#: ____________ Age: ______ Date of Birth: ____________ Sex: ☐ Male ☐ Female

Address: ____________

City: ____________ State: ____________ Zip code: ____________

Home Phone: ____________ Cell Phone: ____________ Work: ____________

Are we permitted to contact you at the numbers listed above? ☐ Yes ☐ No

Contact preference ☐ Email ☐ Phone

Email Address: ____________

Employer: ____________ Occupation: ____________

Address: ____________

City: ____________ State: ____________ Zip code: ____________

Martial Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: ____________

Emergency Contact: ____________ Phone: ____________

Relationship to Patient: ____________ Phone: ____________

Treating Physician: ____________ Phone: ____________

Address: ____________

City: ____________ State: ____________ Zip code: ____________

## OUR POLICIES

### 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.

INITIAL ____________________

### EMERGENCIES & AFTER-HOUR CALLS

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 doctor on call. For routine questions and prescriptions refill requests, we ask that you please call the office on the next business day.

INITIAL ____________________

### 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, 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 requests. Your physician may require you to make an appointment in order to receive refills or if there are any questions or concerns regarding your medications.

INITIAL ____________________

### FINANCIAL POLICY

I understand that I am responsible for all medical expenses, regardless of insurance coverage and whether or not there is an accident with another person at fault.

INITIAL ____________________

Initialing after each section and signing below indicates that you have read and agree to the above policies.

| Patient name | Signature | Date |
|---|---|---|
| ______________________________ | ______________________________ | ____________________ |

## AUTHORIZATIONS AND AGREEMENTS

I, ________________________________________(Patient's name) hereby make the following acknowledgment and agreement regarding the professional services to be provided.

### CONSENT FOR TREATMENT /PROFESSIONAL SERVICES:

I understand that services rendered for the patient by Integrity Spine & Orthopedics and their physicians. I hereby consent to and authorize the administration of services that may be considered advisable or necessary in the judgment of the physician. I authorize any medical records to be obtained by the Integrity Spine & Orthopedics.

### AGREEMENT TO PAV FOR SERVICES:

For and in consideration of the services provided to the patient, I promise to pay the above companies for all charges and services rendered to or in belief of the patient. I also understand that Integrity Spine & Orthopedics will not be filing a claim to my health insurance company, if one exists. 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 rights, privileges and advantages as a third-party beneficiary under that contract.

### DIRECT PAYMENT AUTHORIZATION:

By way of original or copy hereof, the undersigned patient hereby directs (if applicable) the personal injury protection or medical payments insurance carrier to make payment directly to the Integrity Spine & Orthopedics.

### RELEASE OF INFORMATION:

I hereby authorize Integrity Spine & Orthopedics to release any information in the course of my insurance or any physician or attorney needing this information for treatment.

| Patient Name | Patient Signature/Responsible | Party Date |
|---|---|---|
| ______________________________ | ______________________________ | ____________________ |

## NOTICE OF DOCTOR'S LIEN

Patient name: ______________________ Date of Accident: ______________

I hereby authorize my attorney to pay directly to Integrity Spine & Orthopedics ("Provider") such sums as may be due and owing to Provider for medical services rendered me by reason of the accident and to withhold such sums from any insurance settlement, judgement or verdict as may be necessary to adequately protect Integrity Spine & Orthopedics. I hereby further give a Medical Lien on my case to Integrity Spine & Orthopedics against any and all proceeds of my insurance settlement, judgement or verdict which may be paid to my attorney, or myself, as the result of my injuries for which I have been medically treated or injuries in connection therewith.

I understand that Integrity Spine & Orthopedics will not be filing a claim to my health insurance company, if one exists, for services rendered as a result of this accident. In the event that I am a thirdparty beneficiary under a contract between Integrity Spine & Orthopedics and my health insurance carrier, I hereby voluntarily and intentionally waive and relinquish my rights, privileges and advantages as a third-party beneficiary under that contract.

I agree never to rescind this document and that rescission will not be honored by my attorney. I also agree and understand this document to be valid upon my signature. I hereby instruct that the in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to Integrity Spine and Orthopedics and its 3rd party medical vendors for all medical bills for services rendered to me and that this agreement is made solely for the additional financial protection of Provider and in consideration of the Provider awaiting payment. I further understand that as the recipient of the medical services, I remain personally responsible for the payment for these services even if unsuccessful in my personal injury claim and that payment for these medical services is not contingent on any insurance claim settlement, judgement or verdict I may valid and binding on all parties involved as the original.

Patient's Signature ______________________ Date ______________

Attorney's Name ______________________

## NOTICE OF PRIVACY PRACTICES

**ACKNOWLEDGMENT FORM**

I have received a copy of the Notices of Privacy Practices and understand that the notice describes certain rights I have under federal and state law 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.

Signature ______________________ Date ______________

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

______________________

Signature ______________________ Date ______________

## ASSIGNMENT OF BENEFITS

### FINANCIAL RESPONSIBILITY

I understand that the insurance billing service is provided as a courtesy and that I am at all times financially responsible to Integrity Spine & Orthopedics and/or its affiliate entities for any charges not covered by my health care benefits. It is my responsibility to notify Integrity Spine & Orthopedics of any changes in my health coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Integrity Spine & Orthopedics and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

### ASSIGNMENT OF BENEFITS

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary to Integrity Spine & Orthopedics for all covered medical services and supplies provided to me during courses of treatment and care provided by Integrity Spine & Orthopedics and/or its affiliated entities or otherwise as its direction. I understand and agree this Assignment of benefits will have continuing effect for so long as I am being treated or cared for by Integrity Spine & Orthopedics and will constitute a continuing authorization, maintained on file with Integrity SPINE & Orthopedics, which will authorize and allow for direct payment to Integrity Spine & Orthopedics of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Integrity Spine & Orthopedics.

### AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity 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 will e sent to Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by Integrity Spine and Orthopedics.

Patient/Insured Name (print): ______________________ SS#: ______________ Date of Birth: ______________

Patient Signature: ______________ Date: ______________ Witness Signature: ______________ Date: ______________

To: ______________________

Phone: ______________________ Fax: ______________________

I, ______________________ give full authorization to release ______________________ to the physicians of Integrity Spine & Orthopedics for purposes of diagnosing my condition. If you have any questions, please feel free to contact me at the number listed above.

Thank you,

Patient Signature ______________________ Date ______________

Phone Number ______________________ Date of Birth ______________

Contact Person ______________________

**This consent is valid for sixty days from the date of signature.**

## Standard Disclosure and Acknowledgement Form

## Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered**. This means that those services have **already been provided**.
2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name (PRINT or TYPE) ______________________ Signature ______________________ Date ______________

**The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:**

**A.** I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

**B.** The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

**C.** The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

**D.** The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her own hand):*

Name (PRINT or TYPE) ______________________ Signature ______________________ Date ______________

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

**Nota:** The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

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