

## **NEW PATIENT PACKET**

The attached patient forms are provided to you to complete at your convenience. Please bring them with you to your next office visit.

Please Note:

- If the patient is a minor, SpineAustin will need his or her social security number.
- If the patient is a minor, he or she will need to be accompanied by his or her legal guardian.
- Be sure to list all drug allergies.
- We will need all guarantor / responsible party information.
- A complete list of all medications is needed.
- Bring your insurance card(s) and your co-pay.
- Bring any medical records, x-rays or MRIs.
- All cancelled appointments must be called in at least 24 hours prior to your scheduled appointment.

**\*\*IN THE EVENT YOU FORGET YOUR X-RAYS OR MRI SCANS, THE OFFICE MAY RESCHEDULE YOUR APPOINTMENT\*\***

Should you have any questions, please call us at 512-454-1234 or 512-472-6787.

Also, please be advised that due to our practice being a specialty, there may be a wait. We ask for your patience in the event that a delay in your scheduled time occurs.

Thank you,

SpineAustin



3001 Bee Caves Rd. Suite 200 Austin, Texas 78746 P 512.454.1234 F 512.472.7350 spineaustin.com

**DATE:** \_\_\_\_\_

Thank you for choosing **SpineAustin**. Please completely fill out this form to ensure the fastest and best healthcare service. We may ask you to look over this information from time to time to make sure it stays up-to-date.

Patient Name:	Date of Birth:
Address:	Sex: ___Male ___Female
City, State, Zip:	Marital Status: M S D W
Social Security Number:	Employer:
Home or Mobile Phone Number:	Work Phone Number:
Emergency Contact:	Emergency Contact Phone Number:
Insurance company name and policy number- <b>Primary</b> (see Insurance Card):	Insurance company name and policy number- <b>Secondary</b> (see Insurance Card):
Ins. Name: _____	Ins. Name: _____
Policy Holder: _____	Policy Holder: _____
Policy Number: _____	Policy Number: _____
Group Number: _____	Group Number: _____
Primary Care Physician (if applicable):	
If you are covered under the policy of a spouse, partner, parent, or legal guardian, please tell us about them:	
Name of Insured:	Social Security Number:
Date of Birth:	Address:
Home or Mobile Phone Number:	Work Phone Number:
Employer:	Sex: ___Male ___Female
	Marital Status: M S D W
Referring Physician:	Referring Physician Phone Number:



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### Consent to Treat

I authorize the Physicians of **SpineAustin** to provide me with reasonable and proper medical care according to today's standards. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of any procedures and/or treatments.

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

### DISCLOSURE:

Patient contact Information:

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Emergency Contact Name(s): \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you give consent for SpineAustin staff to leave a message with pertinent medical information at the provided phone numbers?

YES

NO

Do you give consent for SpineAustin staff and/or your physician to discuss your medical condition with this person(s) if needed?

YES

NO

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### COBRA PATIENTS:

Cobra patients must provide documentation of active coverage on a month-to-month basis provided by employer.

I \_\_\_\_\_ am currently on a Cobra plan through my employer and am aware that I am responsible for verification of coverage. In the event that I am unable to provide the necessary documentation and my coverage is not valid, I understand that I am personally responsible for all charges incurred at the time services are rendered.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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**Authorization for Release and Disclosure of Protected Health Information**

In accordance with state law and regulatory agency requirements, the health record is the property of SpineAustin. I hereby authorize the PMC Medical Records Custodian to release information from the medical record of:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Alternate Contact Number: \_\_\_\_\_

**Information May Be Released to:**

SpineAustin  
3001 Bee Caves Road, Suite 200  
Austin, TX 78746  
(512) 454-1234

**Facility or Physician:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Please release the following information:**

- Problem List       X-ray Reports       Mental Health       Outside Reports
- Progress Notes       X-ray Films       Drug/Alcohol       Immunizations
- History & Physical Exam       EKG Reports       Lab Reports       HIV/AIDS Test
- Medications       Other Reports (Specify) \_\_\_\_\_

**This information is necessary for the following purpose:**

- Continued Patient Care       Personal Use       Attorney/Legal       Insurance
- Other (Specify) \_\_\_\_\_

1. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol/drug abuse.
2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_. If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.
3. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this in order to receive treatment. I understand that with certain exceptions, I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Health Information Management Manager at (512) 454-1234.

\_\_\_\_\_  
Signature of Parent or Legal Representative

\_\_\_\_\_  
Date



Relationship to Patient

Witness

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

I, \_\_\_\_\_, understand that as part of my health care, SpineAustin originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means to facilitate communication among the many healthcare professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided; and
- A tool for healthcare operations of SpineAustin such as assessing quality of care and reviewing the competence of healthcare professionals.

I understand that as part of SpineAustin’s treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of how SpineAustin may use and disclose my protected my protected healthcare information. I further understand that SpineAustin reserves the right to change its *Notice of Privacy Practices*. Should SpineAustin change its *Notice of Privacy Practices*, an amended copy will be posted in a prominent location in the practice site, or upon my request, an amended copy will be sent to the address I have provided.

I agree that SpineAustin may do the following unless I specifically give direction prohibiting such activity:

- Send visit reminders and test results to the address I have provided.
- Send routine correspondence, such as billing statements, to the address I have provided.
- Leave messages on an answering machine or voicemail associated with the telephone numbers I have provided to either confirm appointments or to request that I call the Practice on medical or billing matters.

\_\_\_\_\_  
Patient’s Signature or Signature of Personal Representative

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY**

- [ ] Receipt received by \_\_\_\_\_ on \_\_\_\_\_.
- [ ] Patient refused to sign receipt. \_\_\_\_\_ (Signature of Practice Rep.)



## Assignment of Benefits Form

### Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

### Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **SpineAustin** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. In the event that I receive the insurance payment, I realize that I will be billed personally until the balance is paid.

### Authorization to Release Information

I hereby authorize **SpineAustin** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from **SpineAustin** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

## Patient Financial Policy

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our billing staff or Business Office Manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- We have made prior arrangements with many insurers and health plans (HMO & PPO) to accept assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.
- Private Pay patients are required to pay in full at the time of check-in.
- Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment for office services are due at the time of service. For your convenience we accept VISA, MasterCard, Discover and American Express. Please be advised that there is a \$20 service charge on all returned checks.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor—in other words you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer we will refund any overpayment to you.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.
- All health plans are not the same and do not cover the same services. In the event that your health plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- Fees for fracture care are often billed as “global” and include fracture care and office visits for a specified time period. X-rays, supplies, cast application fees, etc. is charged separately. Fracture care codes are listed under the insurance code section for surgery even though no “surgery” may have been performed.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.
- In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know that you will need to reschedule your appointment.

**I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time-to-time.**

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Signature of Patient or Responsible Party if a Minor

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Date



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