PRECISION
SPINE & ORTHOPEDICS

w
ww.SpinePrecision.com

Precision Spine & Orthopedics Inc.

222 W. Eulalia St., Suite 309
Glendale, CA 91204-2851

Telephone: (818) 579-2929
Fax: (818) 643-3861

4910 Van Nuys Blvd, Suite 306,
Sherman Oaks, CA 91403

Telephone: (818) 579-2929
Fax: (818) 643-3861

REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle:**	☐ Mr. ☐ Miss ☐ Mrs.	Marital status (circle one below)
				Single / Mar / Div / Sep / Widow

Sex: ☐ M ☐ F	Birth date: / /	Age	SSN / /	Home phone No.:	Cell phone No.:

Street address:	City:	State	ZIP Code:

Occupation:	Employer:	Employer phone No.:

eMail:

If patient is a minor, please provide parent/guardian names and specify relation to the patient:

Referred to clinic by (please check one box):	☐ Dr. Name:				
☐ Family	☐ Friend	☐ Web	☐ Insurance	☐ Hospital	☐ Other

PRIMARY CARE PHYSICIAN

PCP Name: **Last Seen By PCP:**

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship:	Home phone No.:	Work phone No.:
Street address:	City:	State	ZIP Code:

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist)

If the patient is responsible for his/her bill, please skip the next section.

The guarantor is the person responsible for the patient's bill. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.

Person responsible for bill:	Birth date:	Address (if different):	Home phone No.: ( )
Occupation:	Employer:	Employer address:	Employer phone No.: ( )

Work related?	☐ Yes	☐ No	Auto Accident?	☐ Yes	☐ No	If yes, on what date did the injury occur?	/ /

Name of Primary Insurance:

Subscriber's name:	Birth date: / /	Group #:	Policy No.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

Name of Secondary Insurance (if applicable):

Subscriber's name:	Birth date: / /	Group #:	Policy No.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

PHARMACY

Pharmacy name:	Pharmacy Address:	Phone No.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Precision Spine & Orthopedics Inc.,** to access my claims.

Patient/Guardian signature	***Date***

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Financial & Payment Policy

Thank you for choosing us as your health provider. We believe that good care for you and your family starts with good communication, and we have created this policy to help our patients understand their financial responsibilities. If at any time you have questions, please ask us. Please sign below after reading this policy. A copy will be provided to you upon request.

1. **Payment for service.** Payment is due at the time of service unless other arrangements have been made. We gladly accept most major credit cards including Amex, Visa, MasterCard, Discover, and personal checks or cash. Ask us about other financial arrangements available. **ALL IN-OFFICE MEDICAL SUPPLY SALES ARE FINAL AND NON-REFUNDABLE.**
2. **Insurance Coverage.** We participate in most major insurance plans. If you are not insured by a plan that we are a provider for, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
   a. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. To confirm your insurance eligibility, please provide us with a copy of your driver's license and current valid insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
   b. **Coverage changes.** If your insurance changes, please notify us immediately so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in **45 days**, the balance may automatically be billed to you.
3. **Out-of-Pocket Responsibility**: In some cases, our fees may be adjusted based on whether we participate in or accept insurance or government program payments, allowances, or limitations. But, if we present a charge to you, it means that we have taken any such adjustment into account and that you must still pay the amount remaining. If you are reimbursed directly by a program for the cost of your care, you must still pay our charges promptly, whether or not you have received that reimbursement. If you do not agree with patient responsibility amounts or reimbursement amounts set by your insurance or government program, this is a matter between you and that program. We are happy to provide you with factual information about your care and billing to help you discuss this with them, but we still require you to promptly pay the entire charge we present to you, even if your issue with the program is not resolved.
   a. **Copayments and deductibles.** All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
   b. **Non-covered services.** Please be aware that some--and perhaps all--of the services you receive may be non-covered or not considered reasonable or necessary by your insurance plan. You must pay for these services in full at the time of visit.
4. **Claims submission.** As courtesy to you, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
5. **Nonpayment.** If your account is over **60 days** past due, you will receive a letter from us or our agents stating that you have to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have **30 days** to find alternative medical care. During that **30-day period**, your doctor will only be able to treat you on an emergency basis.
6. **Missed appointments.** Our policy is to charge a fee equal to **$50 for missed appointments** NOT canceled or rescheduled prior to 48 hours of your scheduled appointment. This will allow more availability for patients who desire to be seen. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
7. **Returned Checks.** All returned checks will be subject to an external collection service and a **collection fee of $25**. In addition, to cover the cost for returned checks, you will be charged an **administrative fee of $25** (which includes the bank penalty charges incurred) and the cost of certified mailing in the addition to the amount of your returned check amount.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read the above. I fully understand and accept the terms and conditions set forth.

Signature of patient or responsible person: _____

Print Patient Name: _____ Date: _____

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HIPAA - Use & Disclosure of Protected Health Information

Patient Authorization & Acknowledgement of Receipt

Authorization for the disclosure of Protected Health Information (PHI) for Treatment, Payment, or Healthcare Operations (164.508 (a)).

I, the undersigned, understand that as part of my health care, **Precision Spine & Orthopedics Inc.,** originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my health 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;
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

Patient Consent for Use & Disclosure of PHI

Consent to the use and disclosure of Protected Health Information (PHI) for Treatment, Payment, or Healthcare Operations (TPO) (164.506 (a))

I understand that:

- I have the right to review the provider's Notice of Privacy Practices prior to signing this consent;
- The provider reserves the right to revise its Notice of Privacy Practices at any time and that prior to implementation will mail a copy of any revised notice to the address I have provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or health care operations and that the provider has already taken action in reliance thereon.

By signing below, I hereby give my consent to use and disclose my protected health information (PHI) to carry out treatment, payment and health care operations (TPO).

We may also use any of the following methods to send you appointment reminders, patient statements, surveys, occasional news, educational messages, and information related to insurance issues or your clinical care, including laboratory test results, etc:

- **Mail** - to home or other alternate location
- **Telephone** - cell phone, home or alternate number. (We may also leave a message on your voicemail)
- **Text Messages** (standard text messaging rates may apply)
- **Emails**

I understand that I can withdraw my consent at any time.

Signature: _____ **Date:** _____

Print Name: _____ **Telephone:** _____

Complete below if not signed by the patient (please indicate relationship)

Name: _____ Relationship: _____

Address: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify): _____

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ASSIGNMENT OF BENEFITS

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) for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any, directly to the following practice name and address:

Name: **Precision Spine & Orthopedics Inc.**
Billing Address: **1200 S. Brand Blvd., Suite 440, Glendale, CA 91204**

Furthermore, I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **Precision Spine & Orthopedics Inc.** 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 **Precision Spine & Orthopedics Inc.** 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 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.

I have read and agree to all statements, terms and conditions above.

Signature of Patient or Legal Guardian: _____

Print Name:_____ Date: _____