

WHAT TO BRING TO APPOINTMENT:

___ NEW PATIENT REGISTRATION AND MEDICAL HISTORY FORMS

___ MEDICATION LIST / DRUG ALLERGIES

Make list of any medications you are currently taking, including dosages and frequency. Include a list of any drug allergies that you have.

___ INSURANCE COMPANY INFORMATION

Please have your insurance card and insurance company information, including the group number and address where claims should be sent.

___ WORKERS COMPENSATION INFORMATION

Bring the claim number, insurance carrier, claims address, contact person (claim's adjustor) and phone number if you are covered by workers compensation. *Your claim will have to be verified and authorized with your adjustor prior to your appointment.*

___ CO-PAY - If your insurance has a co-payment, you must pay this amount at the time services are rendered (i.e. office visit).

___ INSURANCE AUTHORIZATION / PHYSICIAN REFERRAL

We are on most insurance plans, but be sure your visit with us has been authorized by your insurance company - if this is required. We will not see you if we don't have a required referral and/or authorization. Any questions you may have should be directed to your primary care provider. This is your responsibility. Have your authorization number when you make your appointment with us.

___ X-RAYS, MRI SCAN, CT SCAN, OTHER STUDIES

Please make certain you bring any x-rays, MRI scans, CT scans, etc., as well as any radiology reports. Bring all pertinent studies that have been done.

___ IF YOU REQUIRE DISABILITY FORMS -

We will fill out forms required by the government such as those from the State of Arizona or the Social Security Administration - free of charge. However, if you require disability forms completed for privately-held policies such as those that protect your car, wages, home, or credit cards - *we charge a minimum of \$35 and a maximum of \$50/form(s)*. Your insurance plan will not reimburse you for the preparation of these forms, nor will it reimburse Spine & Orthopedic Specialists; therefore, we require payment before completing the forms. Upon receipt of payment in full and your signature, which acknowledges your understanding of our policy, we will complete your forms.

Authorization for release of information

I authorize SPINE & ORTHOPEDIC SPECIALISTS to release any medical information necessary for purposes of administration, review, investigation, or evaluation of claim coverage and utilization of services.

Assignment of benefits

I authorize the assignment of benefits payable to SPINE & ORTHOPEDIC SPECIALISTS and/or its designee for physician services and supplies by government and/or other private third party payer. I understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles, and non-covered services.

Authorization for additional fees

In the event any lawsuit or action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for any and all costs, not limited to attorney's fees, court costs, collection fees, interest, and any additional costs that this action may incur.

Authorization for treatment

I agree to any examination, treatment, and procedures that may be performed during office visits, including emergency treatment considered necessary by the physician and/or his/her providers.

Acknowledgement of Receipt of Privacy Notice

By signing below I agree I that have received a copy of the **Notice of Privacy Practices for Protected Health Information**.

X _____ | _____
SIGNATURE (Patient or Responsible Party) DATE