

SPARTAN ORTHOPEDIC INSTITUTE

Who referred you to Spartan Orthopedic Institute? _____

Patient Information:

Last Name: _____ First Name: _____ MI: _____ Male Female
Mailing Address: _____ City: _____ State: _____ Zip: _____
Street Address: _____ City: _____ State: _____ Zip: _____
E-Mail Address: _____ Date of Birth: _____
Home Phone: _____ Cell Phone: _____
Social Security #: _____ Marital Status: Minor Single Married Widowed Divorced
Employer Name: _____ Work Phone: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Emergency Contact: _____ Phone: _____

Person Responsible for Bill:

Last Name: _____ First Name: _____ MI: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Social Security #: _____

Insurance Information:

Primary Insurance Company: _____ Telephone #: _____
Policy Number: _____ Group Number: _____
Insured's Name: _____ Date of Birth: _____ Relation to Patient: _____

Secondary Insurance Company: _____ Telephone #: _____
Policy Number: _____ Group Number: _____
Insured's Name: _____ Date of Birth: _____ Relation to Patient: _____

Authorization and Release:

I authorize the release of all medical information necessary to process this claim and is pertinent to my medical care. I authorize and request my insurance company to pay directly to OrthoNorthrup/SOI insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered.

Patient/Guarantor Signature

Date

NEW PATIENT HISTORY FORM

Patient Information

Vital Signs: Height: Height Weight: Weight
 Race Caucasian African American Asian Hispanic Other
 Ethnicity: Hispanic Non-Hispanic Other
 Preferred Language English Spanish Chinese Other
 Preferred Pharmacy PUBLIX PHARMACY #1239
Referral Source:
 Physician: (ex. Dr. John Doe)
 Other: (ex. Google Search, Friend, Other Patient)

Chief Complaint

Dominant Hand:

Right hand Left Hand

Description Of The Symptoms (select only one)

Pain Numbness/Tingling Fracture Stiffness Other:

Shoulder	<input type="checkbox"/> Right <input type="checkbox"/> Left	Pelvis	<input type="checkbox"/> Right <input type="checkbox"/> Left	Neck	<input type="checkbox"/>
Upper Arm	<input type="checkbox"/> Right <input type="checkbox"/> Left	Hip	<input type="checkbox"/> Right <input type="checkbox"/> Left	Upper Back	<input type="checkbox"/>
Elbow	<input type="checkbox"/> Right <input type="checkbox"/> Left	Thigh	<input type="checkbox"/> Right <input type="checkbox"/> Left	Mid Back	<input type="checkbox"/>
Forearm	<input type="checkbox"/> Right <input type="checkbox"/> Left	Knee	<input type="checkbox"/> Right <input type="checkbox"/> Left	Low Back	<input type="checkbox"/>
Wrist	<input type="checkbox"/> Right <input type="checkbox"/> Left	Lower Leg	<input type="checkbox"/> Right <input type="checkbox"/> Left	Buttocks	<input type="checkbox"/>
Hand	<input type="checkbox"/> Right <input type="checkbox"/> Left	Ankle	<input type="checkbox"/> Right <input type="checkbox"/> Left	Tail Bone	<input type="checkbox"/>
Thumb	<input type="checkbox"/> Right <input type="checkbox"/> Left	Foot	<input type="checkbox"/> Right <input type="checkbox"/> Left		
Index	<input type="checkbox"/> Right <input type="checkbox"/> Left	Great Toe	<input type="checkbox"/> Right <input type="checkbox"/> Left		
Middle	<input type="checkbox"/> Right <input type="checkbox"/> Left	2nd Digit	<input type="checkbox"/> Right <input type="checkbox"/> Left		
Ring	<input type="checkbox"/> Right <input type="checkbox"/> Left	3rd Digit	<input type="checkbox"/> Right <input type="checkbox"/> Left		
Little	<input type="checkbox"/> Right <input type="checkbox"/> Left	4th Digit	<input type="checkbox"/> Right <input type="checkbox"/> Left		
		5th Digit	<input type="checkbox"/> Right <input type="checkbox"/> Left		

History Of Present Illness

1. Is Your Problem The Result Of An Injury Or Accident?

No injury Injury Injury at Work Auto Accident Sport Injury Prior Surgery

2. Are You Represented By An Attorney? Yes No

3. Have You Had A Problem Like This Before? Yes No

4. Have You Been Seen In ER For This Problem? Yes No

5. Rate The Pain (10 Being The Most Pain).

0 1 2 3 4 5 6 7 8 9 10

6. Do The Symptoms Wake You From Sleep? Yes No

7. Please Describe The Symptoms.

Sharp Dull Stabbing Throbbing Aching Burning Shooting

8. What Is The Timing Of The Symptoms?

Constant Intermittent (comes & goes)

9. Is The Problem Getting Better Or Worse?

Getting better Getting worse Unchanged

10. What Makes The Symptoms Worse?

Squatting Kneeling Sitting Bending Stairs Twisting Moving Lying in Bed
 Running Walking Athletics Standing Gripping Lifting Reaching Overhead

11. Are There Any Other Symptoms Associated To This Problem:

Redness Bruising Swelling Numbness Stiffness Limping Clicking Locking
 Popping Tingling Weakness Giving way Grinding Instability/Slipping

12. Does your Condition interfere with any of the following

Daily Activities School Activities Work Activities Recreation or Sports Activities

Staff Enter History (Please Type Full Sentences)

Prior Treatment / Testing

Have You Had Any Prior Tests For This Problem?

None X-rays (Where:) MRI(Where:) CAT Scan (Where:) Nerve Test (EMG) (Where:) Bone Scan (Where:)

Have You Had Any Prior Treatments For This Problem? Yes No

Health History Of Patient

No For All

	Yes	No		Yes	No		Yes	No
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Serious Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Other Illnesses	<input type="checkbox"/>	<input type="checkbox"/>

Medical Questions

Mark All That Currently Apply:

Metal in body Claustrophobic Pregnant Sleep Apnea Use a C PAP Sores

Are you taking blood thinners? Yes No

FAMILY HISTORY

Have any direct relatives had any of the following disorders? None for all

Father: None Diabetes Heart Disease Hypertension
 Bleeding Problems Epilepsy Connective Tissue Muscular Dystrophy
 Stroke Osteoporosis Rheumatoid Arthritis Cancer

Comments:

Mother: None Diabetes Heart Disease Hypertension
 Bleeding Problems Epilepsy Connective Tissue Muscular Dystrophy
 Stroke Osteoporosis Rheumatoid Arthritis Cancer

Comments:

Sibling: None Diabetes Heart Disease Hypertension
 Bleeding Problems Epilepsy Connective Tissue Muscular Dystrophy
 Stroke Osteoporosis Rheumatoid Arthritis Cancer

Comments:

SOCIAL HISTORY

1. Do You Smoke Or Chew Tobacco? Daily Occasionally Former user Never How Many Years Smoked? (Packs per day?)

2. Do You Drink Alcohol? Daily Occasionally Rarely Never

3. Marital History: Married Single Divorced Widowed Domestic Partnership

4. Are You Currently Working? Yes No Retired Disabled

Occupation: Employer: Student | Where:

Enter All Below Information Into The Medical Information Tab

Do You Have Any Allergies? Yes No

Medication, Foods, Seasonal Or Metal : NONE

Please List All Medications You Take On A Regular Basis: NONE

Do You Have A Personal History Of Any Of The Following? NONE

- | | | |
|---|--|---|
| <input type="checkbox"/> Aneurysm - Where: | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Angina (chest pain) | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Arthritis - Type: | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> MRSA Infection |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis - Type: | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bone or Joint Infections | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Phlebitis (Blood Clots) |
| <input type="checkbox"/> Cancer - Type: | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Chemotherapy/Radiation | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Reaction to Anesthesia - Type: |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Stomach Ulcers< |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Stroke / TIA |
| <input type="checkbox"/> Diabetes - Type: | Last A1C | <input type="checkbox"/> Tuberculosis |

Other:

Review Of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months? None for all

				Comments
				NONE
1) GI	<input type="checkbox"/> Heartburn, Ulcers	<input type="checkbox"/> Nausea, Vomiting	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/>
2) ENDO	<input type="checkbox"/> Fever	<input type="checkbox"/> Heat or Cold Intolerance	<input type="checkbox"/> Night Sweats	<input type="checkbox"/>
3) CON	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Fatigue	<input type="checkbox"/>
4) EYE	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Vision Loss	<input type="checkbox"/>
5) ENT	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Trouble Swallowing	<input type="checkbox"/>
6) CARDIO	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitations		<input type="checkbox"/>
7) LUNGS	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/>
8) GU	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/>
9) SKIN	<input type="checkbox"/> Frequent Rashes	<input type="checkbox"/> Skin Ulcers	<input type="checkbox"/> Lumps <input type="checkbox"/> Psoriasis	<input type="checkbox"/>
10) NEURO	<input type="checkbox"/> Frequent Falls	<input type="checkbox"/> Loss of Coordination	<input type="checkbox"/> Numbness	<input type="checkbox"/>
	<input type="checkbox"/> Change in bowel	<input type="checkbox"/> Change in bladder	<input type="checkbox"/> Dizziness	
11) PSYCH	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Drug/Alcohol Addiction	<input type="checkbox"/> Sleep Disorder	<input type="checkbox"/>
12) HEM	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Anemia	<input type="checkbox"/>

SPARTAN ORTHOPEDIC INSTITUTE

NOTICE WAIVER AND RELEASE CONCERNING MEDICAL NEGLIGENCE INSURANCE

TO THE PATIENTS OF ORTHONORTHRUP, P.A. dba SPARTAN ORTHOPEDIC INSTITUTE (SOI) AND TOD NORTHRUP, D.O.

Under Florida law, physicians are required to meet certain financial and/or insurance obligations to patients regarding medical malpractice and/or medical negligence. A physician may either purchase medical negligence insurance or otherwise demonstrate financial responsibility, consistent with Florida law, to cover claims for medical negligence up to a required statutory amount.

You are hereby notified that your physician has purchased medical negligence insurance in the amount minimally required under Florida law, \$250,000 per claim and \$750,000 aggregate if there are multiple claimants or claims. However, your physicians have elected not to purchase insurance beyond that which is minimally required under Florida law. The purpose of this notice, waiver, and release is specifically to request, receive, and engage such care only if you waive any right to claim or bring an action against your physician for damage beyond the insured amount and thereby release the physician for any amounts of a claim or action for damages in excess of the insured amount. Simply put, this means that by requesting, accepting, and agreeing to the care of your physician, you understand that you may not and will not assert or collect any claim or other cause of action for damages in excess of \$250,000 per claim and \$500,000 per occurrence. By signing this document, you are knowingly, fully and forever, waiving any and all of the amounts for which the physician and SOI may not be insured. You acknowledge, by your signature below, that neither SOI nor any of its physicians would provide you care without this waiver and release being understood and signed by you.

If you do not agree to this waiver and release, you must signify such disagreement by refusing the treatment and care offered by your physician and seeking another doctor for your health concerns.

By signing this agreement, you are also acknowledging and agreeing that the medical care being provided to you is rendered by an osteopathic medical doctor board certified by the American Osteopathic Board of Orthopaedic Surgery. Consequently, you are agreeing that only a similarly and likewise trained and Board Certified Osteopathic Orthopaedic Physician can or will be in a position to render opinions required by Florida law regarding SOI and Dr. Northrup's practice and care.

By signing this document, you further agree and acknowledge that the medical care you are requesting from your physician and SOI is an elective procedure and your request for care is being made voluntarily and none of the care requested is an emergent or life-threatening requirement at this time. Although the procedures engaged by the physician in treating you may have risks and potentially bad outcomes, as are fully covered in the informed consent documents you will be provided, the condition for which you are requesting care is not at this time life-threatening or an emergency and, hence, is an elective procedure requested by you after counseling with the doctor.

By signing below, you acknowledge that you have fully read and understand this notice, waiver, and release and are agreeing to the provision of care by the doctor and by SOI completely conditioned upon this agreement.

Patient/Guarantor Signature _____ **Date** _____ **Representative of SOI** _____

SPARTAN ORTHOPEDIC INSTITUTE

AGREEMENT AS TO RESOLUTION OF CONCERNS

“I,” “Patient/Guardian” shall be understood to mean:

(Please print patient name)

“Physician” shall be understood to mean Tod Northrup, D.O. and Orthonorthrup, P.A. dba Spartan Orthopedic Institute.

Further, I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) or medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use board-certified expert medical witness(es) in the same specialty as Physician. Furthermore, I agree that these expert medical witness(es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will be members in good standing of an adhere to the guidelines and/or code of conduct defined for expert witnesses by the American Osteopathic Academy of Orthopedics.

In further consideration for this, physician agrees to the same stipulations.

Patient/Guardian Signature

Tod Northrup, D.O.
Physician

Date of Signature

Effective from Date of Treatment

SPARTAN ORTHOPEDIC INSTITUTE

LIFETIME AUTHORIZATION INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

- I. TREATMENT OF INFORMATION -- I hereby give Orthonorthrup, P.A. dba Spartan Orthopedic Institute consent for medical treatment.
- II. RELEASE OF INFORMATION -- I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third party (such as an insurance company or governmental agency, example: Blue Cross of Florida or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.
- III. PHYSICIAN INSURANCE ASSIGNMENT -- I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.
- IV. MEDICARE/MEDICAID -- Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Administration/Division of Family Services of its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.
- V. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by my insurance or third payer within a reasonable period of time not to exceed 60 days. I understand that I will be responsible for all collection fees; these fees will be added to the balance due and could exceed 35% of the original balance. If this account is assigned to an attorney or collection agency for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

DATE _____
PATIENT SIGNATURE

SUBSCRIBER (if different from patient): _____
SIGNATURE

ORIGINAL SIGNATURE ON FILE AT PHYSICIAN'S OFFICE
MEDIGAP (SECONDARY INSURANCE) SIGNATURE

NAME OF BENEFICIARY _____ _____
HEALTH INSURANCE CO. **MEDIGAP POLICY #**

I request that payment if authorized MEDIGAP benefits be made on my behalf to Orthonorthrup, P.A. dba Spartan Orthopedic Institute for any services furnished to me by (physician/supplier). I authorize any holder of medical information about me to release to Orthonorthrup, P.A. dba Spartan Orthopedic Institute any information needed to determine benefits or the benefits payable for related services.

SPARTAN ORTHOPEDIC INSTITUTE

FINANCIAL POLICY

Our health care team is committed to providing you with the best possible medical care. To achieve this goal, we need your assistance, and your understanding of our payment policy. Please be sure to ask any questions you may have regarding this financial agreement, as this will become part of your record.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED.

We accept cash, personal checks, MasterCard, Visa and Discover. Returned checks less than \$50 are subject to a service charge (per Florida Statute 832.08) of \$25. Checks between \$50 and \$300 have a fee of \$30. Checks greater than \$300 will be charged accordingly.

CANCELED or NO-SHOW APPOINTMENTS

Patients who no-show appointments may be discharged from the practice after the third occurrence. Please call to cancel appointments 24 hours prior to scheduled time.

MEDICAL RECORDS

There will be a \$5 administration fee for each medical records request. Your request will be responded to within 14 business days. Patients may request a rush on their records for an additional \$20 fee. The rush request will be available within 3 business days.

INSURANCE

Co-payments, Co-insurance and Deductibles must be paid at the time of service. As a courtesy to you, we will file your insurance claim.

MEDICARE

Deductibles and 20% of the allowable charges are due at the time of service. As we are Medicare providers, we will file your insurance claims. If you have a secondary insurance, please check with the front desk to see if we file with that company. Please bring your Medicare Explanation of Benefits (EOB) showing you have met your deductible.

WORKERS' COMPENSATION

We will file your claim with your company's insurance carrier. In the event, you fail to prosecute the claim for Workers' Compensation (for this illness or condition) or it is determined by the Workers' Compensation Board that this illness or condition is not a result of a compensable Workers' Compensation case, you agree to pay the usual and customary fees for services rendered to you in this case.

CHILD OF DIVORCED PARENTS

Payment is due at the time of service no matter who is responsible by order of the divorce decree.

FINANCIAL AGREEMENT

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance activity. You must realize, however that:

1. Your insurance is a contract between you, your employer and the Insurance Company. We are not party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. (Example: annual physicals)

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.** Any balance on your account over 60 days old, including those balance that insurance has not paid, will be due in full. All accounts over 90 days old will be turned over for collections. You will be responsible for all collection fees; these fees will be added to the balance due and could exceed 35% of the original balance. We realize that emergencies do arise and may affect timely payments of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.

If it becomes necessary for Orthonorthrup, P.A. dba Spartan Orthopedic Institute to collect your balance using an attorney, and/or collection agency then you/or the guarantor agrees to pay all fees associated with collections, including attorney's fees (regardless if suit is filed).

If you have any questions or any uncertainty regarding your insurance coverage, please do not hesitate to ask us. We will assist your accordingly.

I have read and understand the above two-page Financial Policy.

Signature

Date

Witness

Date

SPARTAN ORTHOPEDIC INSTITUTE

CONSENT TO RELEASE OF RECORDS AND INFORMATION CONTEMPLATED BY HIPAA

Patient Name: _____ **DOB:** _____

As a patient of Orthonorthrup, P.A. dba Spartan Orthopedic Institute (SOI), I recognize that the Health Insurance Portability and Accountability Act of 1996 (HIPPA), public law 104-191, constitutes a comprehensive act of protection to ensure the security and confidentiality of my protected health care and account information. I further recognize that SOI, is maintaining protected health information and my patient account record with respect to my care and treatment.

By my signature appearing below, I agree, acknowledge and understand that from time to time it will be necessary for SOI to transmit certain information about my care, treatment, operations, payment and account to third parties to assist in my health care, to protect my health and well-being, and to facilitate the timely and orderly billing and payment for the services I am receiving from SOI.

With this acknowledgment and understanding in mind, and by my signature appearing below, I am specifically consenting to the release, electronic and other transmissions of information with respect to treatment, payment or healthcare operations regarding my care, treatment and services provided by SOI, except that, I request that the following persons or entities not be provided this information unless and until I provide a specific authorization for such release:

I reserve the right to revoke this authorization and/or consent during the term of my care or at any time, but acknowledge that such revocation of authorization will be required to be in writing and signed by me, dated and deliver to SOI.

With these acknowledgments and agreements in mind I voluntarily and knowledgeably consent to the foregoing agreements, understanding and release of information when necessary.

Patient/Guarantor Signature

Date

CONTACT INFORMATION

Patient Name: _____

DOB: _____

I wish to be contacted in the following manner (check all that apply):

- Home Phone: _____
 - O.K. to leave message with detailed information
 - Leave message with call-back number only

- Cell Phone: _____
 - O.K. to leave message with detailed information
 - Leave message with call-back number only

- Work Phone: _____
 - O.K. to leave message with detailed information
 - Leave message with call-back number only

- Other: _____

All written correspondence will be mailed to your home address of record unless an alternate is given below:

Patient/Guarantor Signature

Date

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use of, disclosure of and request for PHI (Private Health Information) to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosure. Information provided here if completed properly, will constitute an adequate record.

NO SHOW AND CANCELLATION POLICY

Orthonorthrup, P.A. dba Spartan Orthopedic Institute has a strict “NO SHOW” and “CANCELLATION” policy. When you schedule an appointment with one of our clinicians, we expect you to attend your appointment. If you need to cancel or reschedule your appointment you must do so at least a full twenty-four hours prior to your scheduled time. As we are an Orthopedic Surgeons office, very often, we have emergency appointments that present. Your consideration of our policy allows for these emergencies to be scheduled in your reserved appointment spot when you cancel prior to twenty-four hours.

We have kindly provided the following information for your review:

Cancellation: Should you decide to cancel/reschedule your appointment for any reason, please call our office at least twenty-four hours before your appointment time. You must call during office hours and speak with a staff member for the appointment to be considered cancelled. Should you fail to do this, your account will be charged \$25. This fee must be paid at the time or prior to your next appointment.

Emergencies: We understand that sometimes genuine emergencies occur; if this is the case, please call our office ASAP as we are most happy to listen to the circumstances and to consider waiving the cancellation/no show fee. Please try and call prior to appointment time!

No Shows: Should you forget your appointment or simply choose not to attend; your account will be charged the \$25 fee. This fee must be paid at the time or prior to your next appointment. If three or more no-shows occur, we reserve the right to dismiss you from this practice. Should you arrive more than 20 minutes late for your scheduled appointment time without a phone call notifying the office of your tardiness you may be charged the \$25 fee.

Orthonorthrup, P.A. dba Spartan Orthopedic Institute is committed to maintaining timely appointments. We realize that sometimes patients may present with a more complex case resulting in your appointment being delayed. We do appreciate your patience when this occurs and will do our best to respect your time – we only ask that you respect ours!

Questions? Don't hesitate to ask one of our Orthonorthrup, P.A. dba Spartan Orthopedic Institute team members.

NO SHOW AND CANCELLATION POLICY

Orthonorthrup, P.A. dba Spartan Orthopedic Institute has a strict “NO SHOW” and “CANCELLATION” policy. When you schedule an appointment with one of our clinicians that time is reserved exclusively for you to discuss and review your orthopedic concerns. We do understand that on occasion unforeseen circumstances do arise and the need to cancel your scheduled appointment may be necessary. If you know that you will be unable to keep your appointment, we ask you to show consideration by calling our office 24 hours in advance. Providing our office with adequate notice will allow us to offer that appointment time to another patient who wishes to be seen. You will be considered a “no show” if an appointment is missed or cancelled with less than 24 hours’ notice. If 24 hours’ notice is not received, a fee of \$25 will be charged to your account. This fee is not covered by insurance and is therefore the sole responsibility of the patient.

I _____ understand and acknowledge that Orthonorthrup, P.A. dba Spartan Orthopedic Institute has a policy to charge me a \$25 fee if I fail to show up for a scheduled appointment. I agree to pay this fee if necessary, and understand I will be unable to schedule future appointments until the fee is paid. It is therefore my responsibility to keep track of the appointments I schedule.

Patient/Guarantor Signature

Date