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	☐ Right ☐ Left	Pelvis	☐ Right ☐ Left	Neck	☐
Upper Arm	☐ Right ☐ Left	Hip	☐ Right ☐ Left	Upper Back	☐
Elbow	☐ Right ☐ Left	Thigh	☐ Right ☐ Left	Mid Back	☐
Forearm	☐ Right ☐ Left	Knee	☐ Right ☐ Left	Low Back	☐
Wrist	☐ Right ☐ Left	Lower Leg	☐ Right ☐ Left	Buttocks	☐
Hand	☐ Right ☐ Left	Ankle	☐ Right ☐ Left	Tail Bone	☐
Thumb	☐ Right ☐ Left	Foot	☐ Right ☐ Left		
Index	☐ Right ☐ Left	Great Toe	☐ Right ☐ Left		
Middle	☐ Right ☐ Left	2nd Digit	☐ Right ☐ Left		
Ring	☐ Right ☐ Left	3rd Digit	☐ Right ☐ Left		
Little	☐ Right ☐ Left	4th Digit	☐ Right ☐ Left		
		5th Digit	☐ Right ☐ 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	☐	☐	Kidney Stones	☐	☐	Phlebitis	☐	☐
Diabetes	☐	☐	Bleeding Disorders	☐	☐	Anemia	☐	☐
Gout	☐	☐	Alcholism	☐	☐	Stomach Ulcers	☐	☐
Seizures	☐	☐	Serious Injuries	☐	☐	Liver Trouble	☐	☐
Mental Illness	☐	☐	Lung Disease	☐	☐	Thyroid Trouble	☐	☐
Kidney Trouble	☐	☐	Tuberculosis	☐	☐	Other Illnesses	☐	☐

Medical Questions

Mark All That Currently Apply:

☐ Metal in body ☐ Claustrophobic ☐ Pregnant ☐ Sleep Apnea ☐ Use a C PAP ☐ Snores

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 Regualr Basis: ☐ NONE

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

- ☐ Aneurysm - Where:
- ☐ Angina (chest pain)
- ☐ Arthritis - Type:
- ☐ Asthma
- ☐ Bone or Joint Infections
- ☐ Cancer - Type:
- ☐ Chemotherapy/Radiation
- ☐ COPD
- ☐ Congestive Heart Failure
- ☐ Diabetes - Type:
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Heart Attack
- ☐ Hepatitis - Type:
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Last A1C

- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ MRSA Infection
- ☐ Pacemaker
- ☐ Phlebitis (Blood Clots)
- ☐ Pulmonary Embolism
- ☐ Reaction to Anesthesia - Type:
- ☐ Stomach Ulcers<
- ☐ Stroke / TIA
- ☐ 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	☐ Heartburn, Ulcers	☐ Nausea, Vomiting	☐ Blood in Stool	☐
2) ENDO	☐ Fever	☐ Heat or Cold Intolerance	☐ Night Sweats	☐
3) CON	☐ Weight Loss	☐ Loss of Appetite	☐ Fatigue	☐
4) EYE	☐ Blurred Vision	☐ Double Vision	☐ Vision Loss	☐
5) ENT	☐ Hearing Loss	☐ Hoarseness	☐ Trouble Swallowing	☐
6) CARDIO	☐ Chest Pain	☐ Palpitations		☐
7) LUNGS	☐ Chronic Cough	☐ Pneumonia	☐ Shortness of Breath	☐
8) GU	☐ Painful Urination	☐ Blood in Urine	☐ Kidney Problems	☐
9) SKIN	☐ Frequent Rashes	☐ Skin Ulcers	☐ Lumps ☐ Psoriasis	☐
10) NEURO	☐ Frequent Falls	☐ Loss of Coordination	☐ Numbness	☐
	☐ Change in bowel	☐ Change in bladder	☐ Dizziness	
11) PSYCH	☐ Depression/Anxiety	☐ Drug/Alcohol Addiction	☐ Sleep Disorder	☐
12) HEM	☐ Easy Bleeding	☐ Easy Bruising	☐ Anemia	☐

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 insure 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 knowledgeably, 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

NOTICE WAIVER AND RELEASE CONCERNING MEDICAL NEGLIGENCE INSURANCE

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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 insure 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 knowledgeably, 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.

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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.

_____ Tod Northrup, D.O.

Patient/Guardian Signature **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 herby 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. I understand and accept it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by my insurance or a third payer that may determine my services as medically unnecessary; within a reasonable period, 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 PHYSICAN'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 Statue 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 feeds 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.

SPARTAN ORTHOPEDIC INSTITUTE

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**

SPARTAN ORTHOPEDIC INSTITUTE

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 your respect ours!

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

SPARTAN ORTHOPEDIC INSTITUTE

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