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World Class Treatment... Hometown Care

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS OR FRIENDS WHO MAY BE INVOLVED WITH MY CARE OR TREATMENT.

Name of Patient

Birth Date

Street Address

City, State & Zip Code

I hereby authorize: Stevens Point Orthopedics
500 Vincent Street
Stevens Point, WI 54481
Phone: 715-344-0701 Fax: 715-344-4494

To release the following protected health care information. YOU MUST CHECK ONE OF THE CHOICES BELOW or nothing can be released.

____ Medical & Billing ____ Medical Only ____ Billing Only

None, I am the only person who is to have access to my medical and billing information.

Name

Relationship

Name

Relationship

Name

Relationship

Name

Relationship

Name

Relationship

I understand this authorization will remain in effect indefinitely unless I notify The Stevens Point Orthopedics in writing of the revocation.

In lieu of my death, this authorization will be null and void.

Signature of Patient

Date

HEALTH INFORMATION

Date ____/____/____

Name _____

DOB ____/____/____

Referring Physician: _____ Primary Care Physician: _____

Are you a: Recreational Athlete Competitive Athlete Team/Sport _____

Employer: _____ Occupation: _____

Is this a Work Comp Related Injury? **N** or **Y**, Date of Injury: _____

Marital Status: Married Divorced Single Widowed

Education Level: High School 2 Yr College Degree 4 Yr College Degree Graduate School

Do you currently smoke/vape/or use e-cig? **N** or ____packs/day Have you ever smoked? **Y** **N**

Chew tobacco? **Y** **N** Drink Alcohol? **N** or ____drinks/day

Past Medical History

AIDs/HIV	Y N	Diabetes Type I	Y N	Osteoarthritis	Y N
Alcohol Dependence	Y N	Diabetes Type II	Y N	Osteopenia	Y N
Anesthetic Problems	Y N	Frequent Falls	Y N	Osteoporosis	Y N
Anxiety	Y N	Gout	Y N	Pacemaker	Y N
Arthritis	Y N	Heart Attack	Y N	Peripheral Vascular	Y N
Asthma	Y N	Heart Murmur	Y N	Positive Bone Density	Y N
Atherosclerosis	Y N	High Blood Pressure	Y N	Pseudo Gout	Y N
Atrial Fibrillation (A-fib)	Y N	High Cholesterol	Y N	Rheumatoid Arthritis	Y N
Bleeding Problems	Y N	Kidney Disease	Y N	Skin Problems	Y N
Blood Clots	Y N	Liver Disease	Y N	Sleep Apnea	Y N
Cancer	Y N	Lupus	Y N	Stomach Ulcers	Y N
Coronary Artery Disease	Y N	Lyme Disease	Y N	Stroke	Y N
Coronavirus (COVID-19)	Y N	Lung Problems	Y N	Thyroid Problem	Y N
Dental Infection	Y N	Malignant	Y N	Vitamin D Deficiency	Y N
Depression	Y N	MRSA	Y N	None of the Above	<input type="checkbox"/>

Other(s) Not Listed: _____

Family Medical History

- First Degree Relatives have no current problems or disabilities
- Unknown

	Father	Mother	Brother(s)	Sister(s)	Son(s)	Daughter(s)
Anesthetic Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type I	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pseudo Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Surgical History

Patient Signature: _____

Stevens Point Orthopedics Patient Financial Policy

Thank you for choosing Stevens Point Orthopedics as your health care provider. We are committed to building a successful physician-patient relationship with you. Your clear understanding of our Patient Financial policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.).

Co-Pays

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check, or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims:

Insurance is a contract between you and your insurance company. In most cases we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information will result in patient responsibility for the entire bill. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

All liability/motor vehicle cases will be filed with your health carrier unless your primary carrier is Medicare, where we are required by law to file with the liability/ motor vehicle insurance. We will assist in supplying you with copies of your billing or claim forms for submission to a liability/motor vehicle carrier.

Referrals and Preauthorization

If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company and the balance will be your responsibility.

Self-pay Accounts

Self-pay accounts are patients without insurance coverage, or patients without an insurance card on file with us. Liability/motor vehicle cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan.

Self-pay patients will be required to bring \$150 at the time of the initial appointment and will be asked to make payment arrangements for the balance. MRI patients must present \$200 at the time of the appointment and will also be asked to make payment arrangements for the balance.

Extended payment arrangements are available if needed. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible with the least amount of stress.

Workers' Compensation

In the case of a workers' compensation injury, it is your responsibility to contact your employer/human resource department, prior to being seen. Please provide us with a claim number, phone number, contact person, and name/address of the insurance carrier prior to your visit. If this information is not provided, you will be asked for payment at the time of your service.

Cancellation

A 24-hour notice of appointment cancellation is requested so that we can fill your time spot with patients who are on a waiting list.

Minors

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statement for any patient under the age of 18. A signed release to treat may be required for unaccompanied minors. If you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

Outstanding Balance Policy

It is our policy that all accounts are paid in full within fifteen (15) days of receipt of statement. If payment in full is not received, or a mutually agreed upon payment plan made within 30 (thirty) days, collection action will commence. Monthly payments that are missed are also subject for immediate collection action.

In the event an account is turned over for collection, the person responsible for the account will be responsible for all collection cost, including attorney fees and court costs. Any further communication will need to be directed to the collection agency.

This financial policy helps our office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please do not hesitate in contacting us.