James Banovetz MD, PhD
Thomas Guse MD
Marcus Haemmerle MD
Mark Jordan MD
Joshua Troyer MD
Todd Williams MD

STEVENS POINT ORTHOPEDICS

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 Date of Birth

_____ _____
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

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

☐ **In the event of my death, this authorization will be null and void.**

_____ _____
Signature of Patient Date

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HEALTH INFORMATION

Name: _____ **DOB:** _____

Referring Physician: _____ **Primary Care Physician:** _____

Are you a: ☐ Recreational Athlete ☐ Competitive Athlete Team/Sport(s)_____

Employer: _____ **Occupation:** _____

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

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Domestic Partner

Education Level: ☐ High School ☐ 2 Year College Degree ☐ 4 Year College Degree ☐ Graduate School

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

Do you chew tobacco? **N** or **Y** Do you drink alcohol? **N** or _____drinks/week

Past Medical History

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

Other: _____

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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	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Atherosclerosis	☐	☐	☐	☐	☐	☐
Bleeding Problems	☐	☐	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Coronary Artery Disease	☐	☐	☐	☐	☐	☐
Diabetes Type I	☐	☐	☐	☐	☐	☐
Diabetes Type II	☐	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐
Heart Murmur	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Lung Problems	☐	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Pseudo Gout	☐	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐
Skin Problems	☐	☐	☐	☐	☐	☐
Stomach Ulcers	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Problem	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐

Surgical History

Have you ever had surgery? ☐ Yes ☐ No

If yes, please explain: _____

Patient Signature _____ **Date:** _____

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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 & 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.