Moreno Spine & Scoliosis

Office Policies

Dear Patient:
We would like to take the opportunity to explain the policies of our office. Please take notice of the following:

Please contact our answering service after hours for **EMERGENCY CALLS** only. This would include fever, changes with your surgical incision or increased pain, **NO** medication refills will be done under any circumstance through these answering service numbers. They may be reached at **727-562-6925.**

All routine calls will be returned within 24 hours, in the order in which they were received.

Please allow 24 hours for prescription refills. To help facilitate these requests, please leave your name, the name of the medication, your birth date and the pharmacy phone number in your message. Under no circumstance will medication refill requests be taken after 5p.m. and over the weekend hours.

If we have ordered imaging studies for you, (x-rays, CT scans, MRI's) it is your responsibility to bring the written reports as well as the actual films to your follow-up visit. Unfortunately, we will have to reschedule your appointment if we don't have all of the appropriate information. All tests will be reviewed by the physician on your follow-up visit, and the results will not be given over the phone prior to that appointment.

Please be assured that we are committed to the highest level of care for you. Please feel free to contact our office at **727-669-5300** for our Safety Harbor patients and **813-870-1206** for our Tampa patients if you should have any further questions.

Thank you for choosing Moreno Spine & Scoliosis to participate in your care.

Sincerely,
Moreno Spine & Scoliosis

I have read and understand the above-mentioned policies.

_____ _____

Patient Signature, Guardian, or Personal Representative Date

2808 West Dr. Martin Luther King Jr. Boulevard, Tampa, Florida 33607 • Phone: 813-870-1206 • Fax: 813-350-0140
3251 McMullen Booth Road, Suite 301, Clearwater, Florida 33761 • Phone: 727-669-5300 • Fax: 727-669-5366

Moreno Spine & Scoliosis

Notice of Privacy Practices

** This notice describes how your health information may be used and disclosed, and how you can access this information. Please review carefully. **

At Moreno Spine & Scoliosis, we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act require us to continue maintaining your privacy to give you this notice and to follow the terms of this notice. This law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we want to call and remind you about your appointment. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your health to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

You have a right to receive a copy of this notice.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (727) 669-5300.

Please initial each space and sign below:

Treatment Agreement

____I promise full cooperation with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, less than optimal results may occur.

Release of Information

___ For the purpose of payment, I allow **Moreno Spine & Scoliosis** to release my Private Health Information to any and all of my insurance carriers, their third party payors and claim reviewers until the claim is resolved. For the purpose of treatment, I also allow **Moreno Spine and Scoliosis** to release my information or contact any and all of my treating physicians.

Acknowledgement of Receipt of Notice of Privacy Practices

____ I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient Financial Policy

1. As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. You must inform the office of all personal (home address, phone numbers, etc…) and/or insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
2. Your payment for office services are due **at the time of service**. We will accept VISA, MasterCard, American Express, Discover and cash or check.
3. Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you with an assignment of benefits if we participate with your carrier. You are agreeing to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 90 days, the patient or guardian seeking care for a minor, will be responsible for payment of services. You are encouraged to contact your designated patient account representative at our office with any questions.
4. Please honor our 24 reschedule notice. At the discretion of our provider, you may be charged a $50.00 no show fee. Repetitive broken or cancelled appointments and/or non-compliance may result in transfer of your care to an alternative practice.
5. We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will require you to pay the co-pay/co-insurance/deductible at the time of service. Your upfront portion will be calculated based on your insurance benefit/limits and our

negotiated fee agreement with your carrier. If you are seeing our doctors on an 'Out of Network" basis, you will be subject to those out of network rates.

6. Not all services are a "covered" benefit in all insurance policies, some plans even impose a waiting period before covering services (pre-existing). In the event your health plan determines a service to be "not covered/pre-existing," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
7. Pre-scheduled Surgical procedures require pre-payment. Your deductible/co-insurance/co-pay for this procedure is due prior to the pre-operative appointment. For additional services provided in the hospital, we wili bill your health plan. Any balance due is your responsibility.
8. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Any payment exceptions will be agreed upon in writing.
9. **PAST DUE** accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.
10. There is a service fee of $35.00 for all returned checks. Upon an NSF or CLOSED ACCOUNT occurrence, all future remittances will need to be in other forms of payment. Restitution, if applicable will be requested from the State's Attorney's Office.

Authorization of Payment

___ I hereby assign all Medical benefits directly to **Moreno Spine & Scoliosis** for the payment of any services rendered. I also authorized release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment.

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

Patient's Name: _____

Signature of Patient/Guardian: _____ Date: _____

Moreno Spine & Scoliosis

Patient Information

Today's Date: _____

Patient's Name: _____ Date of Birth _____/_____/_____

Address: _____

_____

Daytime Phone Number: (____) _____ - _____ Evening Phone Number: (____) _____ _ - _____

Social Security Number: _____ ( ) Male ( ) Female

Primary Insurance: MEDICAL / AUTO / WORK COMP

Accident Related? Auto / Work Comp Date of Accident: _____

Subscriber Name: _____ Subscriber Date of Birth: ___/___/____

Contract Number/ID #: _____ Group Number: _____

Insurance Address: _____

_____

Insurance Phone Number: (____) _____-_____ Adjuster Information: _____

Secondary Insurance: _____

Subscriber Name; _____ Subscriber Date of Birth: _____/_____/_____

Contract Number: _____ Group Number/ID #: _____

Insurance Address: _____

_____

Insurance Phone Number: (_____) _____ - _____

Primary Care Physician or Family Physician: _____

Referring Physician: _____

Address: _____

Phone Number: (_____) _____ - _____

Please have your insurance card(s) and photo ID ready. Payment is expected at the time of your visit.

_____

Patient Signature, Guardian, or Personal Representative Date

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Patient Financial Responsibility Disclosure Form

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Moreno Spine & Scoliosis, for all covered medical services and supplies provided to me during all courses of treatment and care provided by Moreno Spine & Scoliosis. I understand and agree this Assignment of Benefits will have continuing effect for as long as I am being treated or cared for by Moreno Spine & Scoliosis, and will constitute a continuing authorization, maintained on file with Moreno Spine & Scoliosis, which will authorize and allow for direct payment to Moreno Spine & Scoliosis of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Moreno Spine & Scoliosis.

Patient Name (Please Print) _____

Patient Signature _____ Date_____

Responsible Party Name (Please Print)_____

Responsible Party Signature _____ Date_____

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Family Physician Information

Please list the name(s) and address(es) of your family physician or referring physician so we may keep them informed of your progress while under our care.

Family Physician:

Name: _____

Address: _____

Phone: _____ Fax: _____

Referring Physician:

Name: _____

Address: _____

Phone: _____ Fax: _____

Patient Signature: _____ Date: _____

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Disclosure Document

I, _____hereby authorize Moreno Spine & Scoliosis to use or disclose the following protected information: (specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.).

_____
_____
_____
_____
_____

The protected health information may be disclosed: (Insert name(s) of person or entity that may have or receive the information).

_____
_____
_____
_____
_____

This protected health information is being used or disclosed for the following purposes: (List specific purposes here. The patient may indicate that the information to be released is "at the patient's request" if the patient does not choose to provide an explanation of the purpose of the request).

_____
_____
_____
_____
_____

This authorization shall be in force and effective until:

Date: _____

Patient Signature: _____ Date: _____

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Moreno Spine & Scoliosis

Authorization For Release of Medical Information

(Please Print)

Patient Name: _____ Today's Date: _____

Social Security Number: _____ Date of Birth: _____

• I hereby authorize Moreno Spine & Scoliosis to release any information in my chart to any medical practitioner, doctor, hospital, or medical institution/facility to which I may be referred to assist with my care.

• Additionally, I authorize Moreno Spine & Scoliosis to obtain any medical information from any medical practitioner, doctor, hospital, or medical institution/facility to assist in my care.

_____ _____

Signature of Patient, Guardian, or Personal Representative Date

Thank you for choosing Moreno Spine & Scoliosis to provide your surgical care.

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