SPIVEY
ORTHOPEDIC CLINIC

C. Mark Spivey, M.D. * J. Casey Spivey, MD
Board-Certified, Sports Trained Orthopedic Surgeon · Specializing in General Orthopedics and Sports Medicine

Thank you for choosing Spivey Orthopedic Clinic. In order to serve you promptly, please complete the following information. **PLEASE PRINT IN BLACK INK ONLY.** ALL information is confidential.

Patient Name: _____ **Birthdate:** _____

Social Security Number: _____ **Sex:** Male or Female
Address: Street: _____
City: _____ State: _____ Zip Code: _____
Home #: _____ **Cell #:** _____ **Work #:** _____
Email Address: _____
By giving your email address,you consent to email communicatons from our office.
Maritial Status: Married / Single / Divorced / Widow **Preferred Language:** _____
Race: _____ **Ethnicity:** Non-Hispanic / Hispanic

If student, name of school/college? _____

Name of nearest relative not living with you? _____ **Phone #:** _____

Whom may we thank for referring you? _____

Person/Parent Responsible for account (other than patient)

Name: _____ **Phone #:** _____ **Relationship:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Patient/Parent or Guarantor's Employer Information

Employer Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Person to Contact in Case of Emergency

Name: _____ **Phone #:** _____

Insurance Information

Primary Insurance: _____ **Policy #:** _____
Name of Insured: _____ **Relationship to Patient:** _____
Birthdate: _____ **SSN:** _____ **Driver's Lic #:** _____

Secondary Insurance: _____ **Policy #:** _____
Name of Insured: _____ **Relationship to Patient:** _____
Birthdate: _____ **SSN:** _____ **Driver's Lic #:** _____

Workmen's Compensation Information
(complete only if this visit is work related)

Name of Employer: _____ **Phone #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

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MEDICATION REFILLS

I understand and agree that refills for all medications will only be filled during normal business hours, when my complete medical records are available. Normal business hours are Monday thru Thursday, 8:00am to 5:00pm and Friday, 8:00am – 3:00pm. Refill request should be called in before 3:00pm, Monday thru Thursday and before 12pm on Fridays.

X _____ DATE: _____

(SIGNATURE OF PATIENT/LEGAL GUARDIAN)

PAYMENT POLICY

The doctor(s) and staff of Spivey Orthopedic Clinic are committed to providing our patients with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this, we need your assistance and understanding of our payment policy.

All services are provided for a fee for service basis unless you are associated with a managed care plan. In the case of a managed care plan, you will be required to pay your co-pay only. Payments for office visits, insurance co-pays and deductibles are expected when the service is rendered. We accept cash, personal checks and/or credit cards.

AUTO ACCIDENTS / OTHER ACCIDENTS

When your injuries are the result of an accident and an attorney will be handling your case in court or another party's insurance company is presumed responsible for your charges, the patient is still responsible for payment of the bill. Spivey Orthopedic Clinic cannot be expected to wait for the conclusion of long-term court cases or settlement of a disputed insurance claim before being paid.

WORKER'S COMPENSATION

Patients who are injured on the job should report the injury directly to their employer. The employer will be responsible for directing the employee to a doctor who is listed on the PANEL OF PHYSICIANS. Before we will be able to see you as a patient, we will require you to fax or bring in a letter verifying that your employer will be responsible for the charges. If a patient comes in for a visit without this information, we will have to reschedule the appointment. This information is necessary to avoid the patient being responsible for the bill.

MEDICAID

Please bring a copy of your Medicaid card to each visit; otherwise we will have to bill you directly. You will be responsible for all services not covered by Medicaid. This will include certain supplies and any office visits made after your twelve (12) authorized visits.

INSURANCE

Your Insurance coverage is a contract between you and your insurance company. As a courtesy, we will file your office and surgery charges and all Medicare services with your insurance carrier. You may be requested to pre-pay your unmet deductible and co-insurance prior to any surgery performed or following emergency services

You will continue to receive a statement each month even though your insurance is pending. Spivey Orthopedic Clinic cannot accept the sole responsibility for collecting your claim or negotiating a settlement on a disputed claim since we are not party to your insurance contract. If you have a question regarding your account or the filing of your insurance, call Spivey Orthopedic Clinic and ask for the Insurance Department. We will be happy to assist you.

If you need to set up an extended payment arrangement, contact our Insurance Department. If no payment has been received after 90 days from the date the services are rendered, necessary collections procedures will begin with either CBA or TSI.

CONSENT FOR TREATMENT

I, the undersigned, do voluntarily consent to receive treatment, medications, and /or procedures as prescribed by C. Mark Spivey, MD of Spivey Orthopedic Clinic, LLC, and it s designated assistants for the prescribed course of diagnosis and treatment of my illness/injury. I also understand that a parent or legal guardian must be present for treatment of minors (under the age of 18).

AUTHORIZATION FOR SERVICES

The signature below serves as authorization for services rendered by Spivey Orthopedic Clinic for the above named patient, and release of information for payment of services, treatments, and/or operational purposes; and assigns benefits otherwise payable to the policy holder to be made payable directly to Spivey Orthopedic Clinic, LLC. I understand I am financially responsible for any balances not covered by the insurance carrier-a copy of the signature is as valid as the original.

AUTHORIZATION FOR RELEASE OF INFORMATION

The signature below serves as authorization for Spivey Orthopedic Clinic to release or receive medical information for the purpose of patient referral. A copy of this signature is as valid as the original.

X _____ DATE: _____

(SIGNATURE OF PATIENT/LEGAL GUARDIAN

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INSURANCE INFORMATION

Are you enrolled in hospice? [ ] YES [ ] NO
If yes, what is the name and address of your hospice? _____
_____
_____

Are you currently a nursing home resident? [ ] YES [ ] NO
If yes, what is the name and address of your nursing home? _____
_____
_____

If you have Medicare,
Is Medicare your primary coverage? [ ] YES [ ] NO [ ] UNSURE
Are you covered by a Medicare HMO? [ ] YES [ ] NO [ ] UNSURE
(Usually patients from another state – especially Florida have HMO coverage)

X _____ DATE: _____
(SIGNATURE OF PATIENT/LEGAL GUARDIAN)

NO-SHOW POLICY AND FEE

Our office has a strict no-show policy. You are sent reminders via the numbers/emails supplied on this paperwork. This notice informs you that if you can't keep your appointment and choose not to contact the office to cancel it, you will be charged $25.00, to be paid prior to your next appointment.

X _____ DATE: _____
(SIGNATURE OF PATIENT/LEGAL GUARDIAN)

WORKMEN'S COMPENSATION

[ ] NO, I am NOT here due to a work related injury.

[ ] YES, I am here for a work injury and have reported this to my employer. My employer has sent the appropriate authorization for treatment. If you choose this option, your medical insurance will NOT be filed.

WE MUST HAVE AUTHORIZATION TO TREAT YOU FROM YOUR EMPLOYER BEFORE YOU CAN BE SEEN TODAY. IF YOU HAVE NOT REPORTED YOUR INJURY PLEASE SEE THE RECEPTIONIST.

X _____ DATE: _____
(SIGNATURE OF PATIENT/LEGAL GUARDIAN)

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PATIENT COMMUNICATION

(Telephone Numbers listed on Demographic Form will be used as Contact Numbers)
Please make sure these numbers are updated as needed.

[ ] **Do Not** Leave Phone Messages
[ ] **Do Not** Leave Medical Information on Phone Messages
[ ] **Do Not** Contact at Work
[ ] **Do Not** Contact at Home
[ ] Only Speak with Patient
[ ] Only Speak with Designated People
[ ] **You May** Leave Phone Messages
[ ] **You May** Contact via Email

OUT OF NETWORK PAYMENTS TO PATIENTS

It is possible that your insurance company will send you a check for the services of our mid-level practitioners (Physician Assistants) who assist the surgeon in surgery. Many of the insurance companies do not allow Physician Assistants to become a participating provider, so they are considered out-of-network. It is the responsibility of the patient to pay the reimbursement check amount to Mark Spivey Orthopedic Clinic. Also, the information attached to the insurance check will be needed by this office in order to post the payment correctly and make the proper adjustments. If you receive a check from your insurance company and have questions, you can call Kathy Usher or Shanna Scott at (888)537-4411 OR contact your insurance company.

X _____ DATE: _____
(SIGNATURE OF PATIENT/LEGAL GUARDIAN)

PATIENT HIPAA FORM

I hereby authorize Spivey Orthopedic Clinic to share my personal health information with:

[ ] NO ONE other than myself and those required by law.
[ ] My Spouse: _____
[ ] My Parent(s): _____
[ ] My Children: _____
[ ] My Friend: _____
[ ] Other: _____

X _____ DATE: _____
(SIGNATURE OF PATIENT/LEGAL GUARDIAN)

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TRAVEL SCREENING INFORMATION

At Spivey Orthopedic Clinic we care about your health and are following the Centers for Disease Control and Prevention travel screening guidelines. Please complete the following questions upon patient check-in:

HAVE YOU OR ANYONE YOU ARE IN CLOSE CONTACT WITH…

- Been Exposed to COVID-19? [ ] Yes [ ] No

If YES - STOP! - Return to your vehicle and call us at (888)537-4411

Are you / they currently experiencing any of the following symptoms?

Fever (greater than 100.0°F)	[ ] Yes	[ ] No
Severe Headache	[ ] Yes	[ ] No
Muscle Pain / Weakness	[ ] Yes	[ ] No
Diarrhea / Vomiting / Abdominal Pain	[ ] Yes	[ ] No
Respiratory Illness	[ ] Yes	[ ] No
Rash/Skin Irritation	[ ] Yes	[ ] No
Unexplained Bleeding or Bruising	[ ] Yes	[ ] No

Signing below confirms you have received a copy of the Patient/Visitor Protocol:

_____

Patient Signature Date/Time

Clinical Staff Notification Required? _____Yes _____No
[ ] Language/Translation Line Utilized

Revised 6/30/2020

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COVID-19 Protocol

At Spivey Orthopedic Clinic, we care about your health and are taking the following precautions:

Patient/Visitor Protocol:

- We request that you bring **ONLY ONE FAMILY MEMBER / VISITOR** with you for your scheduled procedure and / or appointment.
- When you arrive for your procedure / appointment, you will be asked a series of questions to verify that you do not have symptoms of COVID-19 or any other infectious disease or been exposed to COVID-19.
- Seating will be limited to allow for 6 feet between seats. If there are no seats available, you may sit in your vehicle. Please leave a phone number with the front staff, so we may call you when they are ready for you.
- Patients are recommended to wear masks.
- Patients need to take their temperature at home prior to their appointment. It should be less than 100.0

If you feel you or anyone you are in close contact with have symptoms of any infectious disease, please return to your vehicle and call us at (888)537-4411.