TEXAS Bone & Joint

PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____ Patient Social Security Number: _____-_____-_____

Address: _____

City, State, Zip: _____Home #:_____Cell #:_____

Employer: _____Work Phone #: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ NativeHawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic
☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Other not listed_____

PCP Name: _____ PCP Phone #:_____

Pharmacy Name: _____ Cross Street _____ Phone: _____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self ☐ Check here if address and telephone information is same as patient
Responsible party name: (Last)_____(First)_____(MI) _____
Date of birth:_____ ☐ Female ☐ Male Responsible Party Social Security Number:__-_____-_____ Phone #: _____
Address: _____ City, State: _____ ZIP:_____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____
Emergency Contact Phone #:_____ Do you have a living will? ☐ Yes ☐ No
Emergency contact relationship to patient: _____ ☐ Guardian _____
Address_____ City_____ State_____ Zip_____

Home phone#:_____ Cell Phone#: _____Work Phone#:_____Ext._____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____ Date: _____

Printed name of patient or personal representative:_____Relationship to patient: _____

TEXAS Bone & Joint

PATIENT HEALTH HISTORY

Patient Name:_____ Age:_____ [ ] Female [ ] Male Dominant Hand: [ ] Right [ ] Left

What is the main reason for your visit today: [ ] Pain [ ] Numbness [ ] Weakness [ ] Swelling [ ] Stiffness
[ ] Other:_____

Did you bring x-rays: [ ] Yes [ ] No

What Body Part is involved? Please mark in the table below: ****We will evaluate one body part per visit**

Shoulder [ ] R [ ] L	Elbow [ ] R [ ] L	Hand [ ] R [ ] L	Pelvis [ ] R [ ] L	Knee [ ] R [ ] L	Foot [ ] R [ ] L
Arm [ ] R [ ] L	Wrist [ ] R [ ] L	Finger [ ] R [ ] L T 2 3 4 5	Hip [ ] R [ ] L	Ankle [ ] R [ ] L	Toe [ ] R [ ] L T 2 3 4 5
Back Pain [ ] Radiates to: R leg [ ] L leg [ ]	Neck pain [ ] Radiates to: R arm [ ] L arm [ ]	OTHER: [ ]	OTHER: [ ]	OTHER: [ ]	OTHER: [ ]

How long ago did your symptoms start? _____Days _____Weeks _____Months_____Years
Have you had a problem like this before? [ ] Yes [ ] No

In this section, check the **ONE BOX** which best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

Comments:

[ ] **No Injury** (Onset was: [ ] Gradual [ ] Sudden)
Why do you think it started? [ ]

[ ] **Injury** ([ ] Sport [ ] Accident-**Not Auto or Work**)
Date:_____Where and how did it happen?
What Sport? _____

[ ] **Injury at Work**: Date: _____
From a [ ] Lift [ ] Twist [ ] Fall [ ] Bend [ ] Pull [ ] Reach _____

[ ] **Work Related-No Injury**
Date:_____How did your job cause this problem? _____

On a Scale of 0-10 (10 is the worst) how ***severe*** is your pain? (Circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? [ ] Sharp [ ] Dull [ ] Stabbing [ ] Throbbing [ ] Aching [ ] Burning

The pain is: [ ] Constant [ ] Comes and Goes Does your pain wake you from sleep? [ ] Yes [ ] No

Do you have any of the following? [ ] Swelling [ ] Bruising [ ] Numbness [ ] Tingling [ ] Weakness

Since my problem started, it is: [ ] Getting Better [ ] Getting Worse [ ] Unchanged

What makes your symptoms ***worse***? [ ] Standing [ ] Walking [ ] Lifting [ ] Exercise [ ] Twisting
[ ] Lying in bed [ ] Bending [ ] Squatting [ ] Kneeling [ ] Stairs [ ] Sitting [ ] Reaching Overhead
[ ] Reaching Behind your back

What makes your symptoms ***better***? [ ] Rest [ ] Elevation [ ] Ice [ ] Heat [ ] Other: _____

What Medications are you currently taking for ***this problem***? _____

Have you had any of these treatments for ***this problem***? [ ] Injection [ ] Brace [ ] Physical Therapy [ ] Cane/Crutches
What Scans/Tests have you had for ***this problem***? [ ] X-Rays [ ] MRI [ ] CT Scan [ ] Bone Scan[ ] Nerve Test (EMG)
Current Work Status? [ ] Regular [ ]Light Duty (how long?_____) [ ] Not working due to this problem
[ ] Disabled [ ] Retired [ ] Student [ ] Unemployed

Occupation: _____When is the last date you worked at your job? _____

Social History:

Do you use tobacco?[ ]Yes, Packs/day [ ]No [ ] Previous Smoker, stopped smoking when? _____
Alcohol Use?[ ]None [ ]Social [ ]Daily [ ] Frequently **Illegal Drug Use?** [ ] Yes, what type?_____ [ ] No

Review of Systems:

Current Symptoms: [ ] None

CONST: [ ] Chills [ ] Fever [ ] Night Sweats

SKIN: [ ] Open Sores

EYE: [ ] Blurred Vision [ ] Double Vision [ ] Eye Pain

RESP: [ ] Chronic cough [ ] Shortness of Breath

C-VASC: [ ] Chest Pain [ ] Irregular Heartbeat

GU: [ ] Painful Urination [ ] Trouble Starting Urination

GI: [ ] Abdominal Pain [ ] Dark Black Stool [ ] Vomiting Blood [ ] Blood in Stool

M/S: [ ] Pain in Joints [ ] Pain in Muscles [ ] Morning Stiffness [ ] Swollen Joints

PSYCH: [ ] Depression [ ] Anxiety [ ] Hearing Voices

Neuro: [ ] Headaches [ ] Dizziness [ ] Poor Coordination [ ] Numbness

Past Medical History:

Have you ever been diagnosed with any of the following conditions? Check all that apply [ ] None

[ ] Asthma [ ] Stroke [ ] Heart Attack (when?_____) [ ] High Cholesterol
[ ] Kidney Failure [ ] Heart Failure [ ] Cancer (location?_____) [ ] High Blood Pressure
[ ]Ulcers [ ] Hepatitis [ ] Seizures [ ] HIV [ ] Emphasyema/COPD
[ ] Diabetes [ ] Blood Clots(DVT) or PE [ ] Thyroid Problem [ ] Bipolar Disorder

[ ] Liver Disease Notes/Other: _____

Allergies: Do you have any ***Allergies*** to any medications? [ ] Yes [ ] No If Yes, please list below:

Medication	Reaction

Family History: What illnesses have been in your family? List illness and family member affected [ ] None

_____

_____

Past Surgical History: What Operations have you had (for any reason)? [ ] None _____

_____

Past Hospitalizations: [ ] None _____

New Diagnosis: [ ] None _____

UPDATED MEDICATIONS			
Name	Dose / Strength	Frequency	Prescribing Physician
Example: Metoprolol	*40 mg*	*2 tabs in a.m. & 1 tab in p.m.*	*Dr. Jon Smith (Internal Medicine Doctor)*

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (Or Responsible Party) Signature: _____ **Date:** _____

TEXAS Bone & Joint

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

NOTICE OF PRIVACY PRACTICE/CLINICS

_____ **(Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

COMMUNICATIONS ABOUT MY HEALTHCARE

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

CONSENT FOR PHOTOGRAPHING OR OTHER RECORDING FOR SECURITY AND/OR HEALTH CARE OPERATIONS

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

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RELEASE OF INFORMATION

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc.)	Date

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

Name	Relationship to Patient

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

TEXAS Bone & Joint

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

Patient name: _____ Date of birth: _____

FINANCIAL AGREEMENT

- I acknowledge, that as a courtesy, TEXAS BONE & JOINT may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge TEXAS BONE & JOINT may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to TEXAS BONE & JOINT any insurance or other third-party benefits available for health care services provided to me. I understand TEXAS BONE & JOINT HAS the right to refuse or accept assignment of such benefits. If these benefits are not assigned to TEXAS BONE & JOINT, I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to TEXAS BONE & JOINT by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for TEXAS BONE & JOINT or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that TEXAS BONE & JOINT or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or TEXAS BONE & JOINT or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ **Date:** _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

- ☐ Spouse
- ☐ Parent
- ☐ Legal Guardian
- ☐ Guarantor
- ☐ Healthcare Power of Attorney
- ☐ Other (please specify) _____

NOTICE OF CHARGES FOR FORM COMPLETION

✡ **Disability** ✡ **FMLA** ✡ **Supplemental Insurance** ✡ **Dictated Work Excuse** ✡ **Medical Hardship Letter**

- ❖ Due to high volume of form completion request, please submit your forms in a timely manner. The fee must be paid prior to the forms being returned, faxed or mailed by your provider.
- ❖ Form Completions Fee is $25.00 per occurrence which is payable by cash or credit card.
- ❖ The patient information portion MUST be completed by the patient PRIOR to processing
- ❖ Once we receive your form(s) and signed authorization to release your medical information, please allow 5-7 business days for processing.
- ❖ Should you have any questions, please contact our staff @ 877.314.8990

PRACTICE POLICY PROCEDURES: Our goal is to provide an **EXCEPTIONAL** healthcare experience. We believe it is necessary to establish and provide a copy of our guidelines/policies regarding the following:

WAIT TIMES **LATE ARRIVAL POLICY** **PHYSICIAN/INSURANCE REQUIRED REFERRALS**
TELEPHONE CALLS/MEDICAL QUESTIONS **FORM COMPLETION FEE**

☐ I have read and understand and will adhere to the PRACTICE POLICY & PROCEDURE Form

_____ _____

Patient/Guardian Signature **Date**

TEXAS Bone & Joint

PATIENT CONTROLLED SUBSTANCE AGREEMENT

Controlled substances are drugs we prescribe to reduce, but not cure your pain. As doctors, we want to provide the best care for your problem; however, because of the concerns we have when we prescribe controlled substances, we feel it is necessary to notify you of our expectations.

When taking controlled substances, it is important to understand that the medications can lose their effectiveness if not taken as prescribed. Side effects may occur, including constipation, drowsiness and sedation. If this occurs, please notify us. It is also important for you to know that, in rare cases, psychological addiction may occur. We do not want psychological addiction to be a problem for our patients; if this occurs, your controlled substance prescription may be stopped. As doctors, we are under strict regulation by the law, and have guidelines we must follow in prescribing all drugs. Rules of this Controlled Substance contract are for your comfort and to yield maximum benefit:

1. You agree that **if you lose** your controlled substances or prescriptions for any reason, you **will not get** a replacement prescription for your controlled substance.

2. You agree that **your prescriptions will be given to you on your appointment day only; do not call the clinic for controlled substance medications.**

3. You agree to **use only one pharmacy** to fill your controlled substance prescriptions.

4. You agree to **show up for all your appointments** here, and provide notification at least 24 hours in advance if you are unable to come to your appointment.

5. **You agree that you will take the controlled substance medications exactly as prescribed and will not take more pills in one day than allowed**.

6. **You agree that you will obtain controlled substances only from this office**. If you have an injury or develop a new pain problem between your clinic visits here (i.e. go to the Emergency Room etc.), and receive controlled substance medications you agree to notify us immediately of the medicine, the dosage, and the number of pills given.

7. You agree that **you will not sell or share** your controlled substances.

8. You agree to notify this office immediately if you become pregnant.

9. **You agree that a drug screen may be performed from time to time without notice**.

10. You agree that if **any of these rules are broken, controlled substance therapy may stop**.

11. **You agree that if your doctor gives you a referral to see a Pain Specialist, it is your responsibility to make an appointment** with that doctor/group. The Pain Specialist will manage your pain medications form that point forward. After the referral has been completed, we will not refill your pain medications in this office.

12. You agree as a part of your treatment plan **to see a specialist as referred**. This may include Orthopedist, Physical Medicine specialist, and or Psychiatrist. Non-compliance with these referrals can result in your dismissal from this practice.

You have read and understand all the above expectations and agree to be held to the terms in full.

If these terms are not upheld, the physician may decide, with proper notice to stop treating you completely.

Texas Bone and Joint -Policy on Narcotic Medications

In 2010, there were 8.76 million prescription abusers in the United States. On October 6, 2014, the Drug Enforcement Agency determined that all the hydrocodone products are now Schedule II restricted prescriptions. Prescriptions of these medications now requires a special prescription form issued by the government. These prescriptions cannot be renewed over the phone and include

Hydrocodone – Norco – Vicodin – Percocet – Oxycodone - Oxycontin

Therefore, it is the policy of this office that the above medications will be provided for patients only immediately after surgery and for the use after discharge from the hospital. At the time of your first follow up visit and thereafter, if you require ongoing pain medication, you will be asked to schedule an appointment with a Pain Management doctor.

Patient's Signature_____ Date_____

Physician's Signature: _____Date _____

TEXAS Bone & Joint

X-RAY CONSENT FORM

Patient Name: _____ DOB: _____

During your examination, the doctor may feel that x-rays will be needed in order to diagnose your condition. We would like to make you aware that x-rays may be required in order to administer treatment.

Please Choose One

☐ I understand that my doctor may need x-rays in order to diagnose my condition. I give permission for all x-rays needed.

☐ I understand that my doctor may need x-rays in order to diagnose my condition. I choose **NOT** to have x-rays at this time and release my doctor of all liabilities.

FEMALES ONLY

This is to certify that to the best of my knowledge I am not pregnant. My doctor has my permission to perform a diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

With those factors in mind, I am advising my doctor that:

I am pregnant	☐ yes/ ☐ no/ ☐ don't know
I could be pregnant	☐ yes/ ☐ no/ ☐ don't know
My menstrual period is late	☐ yes/ ☐ no/ ☐ don't know
I am on some form of birth control	☐ yes/ ☐ no/ ☐ don't know
I have had tubal ligation	☐ yes/ ☐ no
I have had a hysterectomy	☐ yes/ ☐ no
Menopause	☐ yes/ ☐ no

With full understanding of the above and believing I am currently not at risk, I wish to have x-rays performed today if requested by my doctor.

_____ _____

Signature Date

COPY FOR YOUR RECORDS

TEXAS Bone & Joint

COPY FOR YOUR RECORDS

Welcome To Our Practice!

Our goal is to provide an exceptional healthcare experience. We believe that in the interest of best healthcare practices a copy of our policies and procedures is being provided to you in order to avoid unwanted communication errors or misunderstandings of what is expected in a healthy Doctor-Patient relationship.

WAIT TIMES

Your time is valuable and that every patient has unique needs that may require more time than planned. We will make every effort to provide proper care and minimize your in office wait time. Unforeseen emergencies/surgeries that take longer than anticipated may arise and cause a delay or rescheduling of your appointment. We will exhaust efforts to accommodate your schedule and notify you as soon as we are aware of the delay.

LATE ARRIVAL

It is our policy that if you are more than 15 minutes LATE arriving to your scheduled appointment, you may encounter longer wait time or a need to have your appointment rescheduled. Please call our office prior to your appointment if you anticipate a delay in your arrival time.

PHYSICIAN AND HMO REFERRALS

It is the responsibility of the patient to obtain and provide a valid referral from your Primary Care Physician (PCP) and to ensure that our office staff has them PRIOR to your appointment. Failure to do so may result in insurance denial of your visit and payment/financial responsibility directly transferred to the patient as a result.

TELEPHONE CALLS AND MEDICATIONS

Each provider has a dedicated clinical team to assist in providing care. Except in life or limb threatening emergencies our physician/clinical staff do not accept calls while in clinic with the patients. If you are calling during those times, the front clinic staff will take a detailed message. The clinical staff will gladly respond to your calls within 24 hours depending on the urgency. If your call is after 5pm, the clinical team will return your call the following business day.

FORM COMPLETION

There will be a $25 charge per occurrence for the completion of the following forms:

Disability **FMLA** **Supplemental Insurance** **Dictated Work Excuse** **Medical Hardship Letter**

- Due to high volume of form completion request, please submit your forms in a timely manner. The fee must be paid prior to the forms being returned, faxed or mailed by your provider.
- Form Completions Fee is $25.00 per occurrence which is payable by cash or credit card.
- The patient information portion MUST be completed by the patient PRIOR to processing
- Once we receive your form(s) and signed authorization to release your medical information, please allow **5-7 business days** for processing.
- Should you have any questions, please contact our staff @ 877.314.8990