Alpine Spine Center, P.C.

Cathleen S. Van Buskirk, M.D.

Diplomate American Board of Orthopaedic Surgery

All of the information on this record is confidential and will not be released unless authroized by you				
Patient Information	Referring Physician & Phone		Primary Physican & Phone	
	Last Name	First Name		Middle Name
	Address 1			
	City	State		Zip
	Home Phone	Cell Phone		Work Phone
	Date of Birth	Age	Sex	Marital Status
	Employer Name/Address/Phone #			
	Occupation			
	Social Security #			
	Allergies (list below, please)		Circle if None	
	Emergency Contact:	Relationship:		Phone:
	With whom may we discuss your health issues:			
	Name		Relationship	

PRACTICE AND FINANCIAL POLICIES

Our commitment to you, our patient, is to provide the highest quality healthcare service possible. We are also committed to the health of our practice. With these considerations, the following are the business policies of our practice:

APPOINTMENTS: Your appointment time has been allotted based upon the expected time to provide the service requested. Additional services not scheduled will require another appointment

REFERRALS: Obtaining a referral is your responsibility and must be obtained prior to your appointment. If the referral is not obtained, you may reschedule the appointment or sign a waiver. If the waiver is signed, and a referral is not obtained, you will be financially responsible for all charges.

INSURANCE: Not all services are a covered benefit. Some insurance carriers arbitrarily select certain procedures they will not cover. Your insurance policy is a contract between you and your insurance carrier. It is the patient's responsibility to review and understand their own policy and benefits. We are not a party to that contract. We will file your insurance claim 2 times, if necessary. If it is denied, it will be your responsibility to follow up with the insurance carrier to resolve the claim. Alpine Spine Center, P.C and all entitles used in your care are out of network with United Healthcare and Anthem Blue Cross Blue Shield. If you have any of these insurances, we will bill through your out of network insurance. Alpine Spine Center, P.C may use my health care information and may disclose such information to your insurance carrier(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

PAYMENT PROCEDURES: All patients are required to pay their balance 30 days from receiving your statement. Cash patients: All cash payments must pay the cash fee at the time of service. Any collection fees, court costs, reasonable attorney fees or returned check fees are the responsibility of the adult person(s) named on the account.

LATE CANCELLATION AND NO SHOW FEES: A fee of $50.00 will be billed to you for an appointment that is missed or for canceling an appointment less than 24 hours prior to the scheduled appointment time.

CONSENT RELATED TO PRIVACY NOTICE: I, with my signature below, have had a chance to review the HIPAA Notice of Privacy Practices as part of this registration process. I understand that the terms of the Privacy notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. As stated in such notice, I understand if I choose to communicate by email, this is unsecured, and I do so at my own risk.

CONSENT FOR TREATMENT: I, with my signature below, authorize Alpine Spine Center, P.C., and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

CONSENT FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS: In addition, with my signature below, I authorize this practice to furnish information to the identified insurance carrier(s), including Medicare, for any and all payment activities. I consent to assign directly to Alpine Spine Center, P.C and all agents/entities used by Cathleen Van Buskirk, M.D., all surgical and/or medical insurance payments, if any, otherwise payable to me for services rendered. I understand I have 30 days from the check issuance to endorse the check to Alpine Spine Center, P.C. and send with a copy of the original explanation of benefits.

I also verify that all the information contained on these information sheets is true and correct, to the best of my knowledge and belief.

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Signature of Patient or Parent/Guardian if patient is a minor Date