

# ALPINE SPINE CENTER, P.C.

CATHLEEN S. VAN BUSKIRK, M.D.

DIPLOMATE AMERICAN BOARD OF SPINE SURGERY  
 DIPLOMATE AMERICAN BOARD OF ORTHOPAEDIC SURGERY

All of the information on this record is confidential and will not be released unless authorized by you.

PATIENT INFORMATION	Referring Physician		Primary Care Physician		
	First Name		Last Name		MI
	Address				
	City		State		ZIP
	Home Phone		Cell Phone		Work Phone
	Date of Birth		Age		Sex
	Employer Name/Address/Phone #				
	Occupation				
	Social Security #				
	Allergies:		Circle if NONE		
	Emergency Contact		Relationship		Phone
	With whom may we discuss your health issues:				
	Name		Relationship		
	Name		Relationship		

Practice and Financial Policies	<p>Our commitment to you, our patients, 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:</p> <p><b>APPOINTMENTS:</b> Your appointment time has been allotted based upon the expected time to provide the service requested. Additional services not scheduled will require another appointment.</p> <p><b>REFERRALS:</b> Obtaining a referral is <b>your responsibility</b> and must be obtained prior to your appointment. If the referral is not obtained, you have a choice of rescheduling the appointment or signing a waiver. If the waiver is signed, and a referral is not obtained, you will be financially responsible for all charges.</p> <p><b>INSURANCE:</b> Not all services are a covered benefit. Some insurance companies arbitrarily select certain procedures they will not cover. Your insurance policy is a contract between you and your insurance company. 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 company to resolve the claim.</p> <p><b>PAYMENT PROCEDURES:</b> All patients are required to have a credit card on file. For all balances over \$300.00 We will call and give you the option of paying the full balance with the credit card on file or choosing a different payment method.</p> <p>Cash patients: All cash payments must pay the cash fee at the time of service.</p> <p>Any collection fees, court costs, reasonable attorney fees or returned check fees are the responsibility of the adult person(s) named on the account. Monthly service fee of 1.5% per month or 18% per annum will be assessed on all past due accounts.</p> <p><b>LATE CANCELLATION AND NO SHOW FEES:</b> 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.</p>
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**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN**

I hereby irrevocably authorize payment directly to the physician of the surgical and/or medical benefits, if any; otherwise payable to me for his services, as described, realizing I am responsible to pay non-covered services.

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

**INSURANCE/MEDICARE ASSIGNMENT**

I request that payment under INSURANCE/MEDICARE be made to Cathleen S. Van Buskirk, M.D. for services provided to me. I also authorize the provider of service to release to the Social Security Administration or its agents, information for this or any INSURANCE/MEDICARE claim. I also permit a copy of this authorization to be used in place of the original.

**ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICE POLICY**

In accordance with the Health Insurance Portability Accountability Act beginning April 14, 2003, the office of Alpine Spine Center, PC is required to maintain the privacy of every patient's Personal History Information. The purpose of the Privacy Practices Policy is to assure that an individual's health information is properly protected while allowing the flow of health information needed to provide high quality health care. I understand the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan and direct my treatment and follow-up among multiple health care providers who may be involved in my treatment directly and indirectly; obtain payment from third-party payors; conduct normal health care operations such as quality assessments and physician certifications.

I understand that an accurate copy of these privacy practices is available upon request. The description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I hereby acknowledge that The Notice of Privacy Practices Policy has been made available to me.

Patient Name

Signature (Patient or Parent of Minor):

Date:

**FOR OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented below.

Date:

Initials:

Reason: