Dr Jennifer Stebbing DO
MUSCULOSKELETAL & SPORTS MEDICINE

Patient Information and Service Agreement

Welcome. This form has been developed to introduce you to the practice and clarify policies, responsibilities, and billing procedures.

We are committed to our Mission: To treat injuries and pain by providing comprehensive evaluation of the musculoskeletal system and a personalized plan to promote healing, increase function and decrease pain, allowing for the full return to activity, including sport.

We welcome new patients with an initial appointment of 40 to 90 minutes. Please complete the intake form prior to your scheduled appointment so we can utilize all of the time to address your needs.

Follow up visits are typically 30 to 40 minutes.

Initial____ **Missed or cancelled appointments with less than 2 business days' notice.** It is your responsibility as the patient to keep the appointment time even though reminder calls, emails and texts will be made. Please call or email, us to verify the time if you have forgotten it**. Your credit card will automatically be charged $100** for missed or appointments cancelled inside of 2 business days. This fee will not be charged if we both agree that circumstances existed that were beyond your ability to predict or control.

Initial____ **Billing Policy**
We are in the process of being contracted with some insurance companies, which may have out of network benefits. You as the guarantor are responsible for all out of network fees. Please check with your insurance company to find out if you have out of network benefits.

Initial____ **Referrals** are welcomed to improve communication from your Primary Care Physician. Please also provide me with the information I need to communicate with your PCP to ensure continuity of care.

Initial____ **Payments** are accepted in the form of *cash, check or credit card*. A **$35 service fee** will be charged for all **returned checks**.

Initial____ If you have any questions please about billing contact our **Biller, Suzanne Keefe @ 866-828-8901.**

Initial____ **Please be aware** that some, and perhaps all, of the services you receive, may not be covered by insurance or may not be considered 'reasonable' or 'necessary'. These are the terms defined by each insurance company. Please contact them with any questions you might have. Services not covered by your insurance company are your responsibility. This includes **All PRP, Stem Cell and Prolotherapy injection treatments,** which are payable at the time of service. **HSA or Flex Spending Accounts may be used**

Initial____ **Self-pay charges** (if you do not have insurance or have an insurance that is out of network, payment is due at the time of service. The fees are: **Initial Visit ($350) or Follow Up ($200)**

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Initial____ **Communication:** Brief communication by email or phone is acceptable for appointment inquiries and general questions. Phone messages left at our office (360) 258-1746 will be retrieved daily during the work week.
*****Call backs may occur after business hours, so please leave non-work numbers.***

Initial____ **The adult accompanying a minor and the parents (or guardian of the minor)** are responsible for payment at the time of service and any subsequent balances. For unaccompanied minors, non-emergent treatment will be denied unless charges have been pre-authorized or payment by credit card, cash or check at the time the service has been verified.
*****True emergencies need to be addressed through the ER or by calling 911.***

Initial____ **Acute urgencies**; we will make the best effort to accommodate unplanned injuries. During periods that we are not available contact your PCP or other practitioners (massage, chiropractic, PT) to assist you.

Initial____ **Photos and Video Images** can be important ways to document your benefits from treatment. We have your permission to take images of you for in office use only.

Initial____ **Video and Written Testimonials** for the purpose of marketing may be done with your permission. Typically, a brief reason for why you sought treatment for, your experience and your outcome is discussed without revealing anything too personal. We reserve the right to edit and use these for marketing in a tasteful and respectable way.

Initial____ **HIPAA Compliance.** This government law was made to protect your personal identification and personal information from being shared with any organization or anybody that you don't personally approve of. We maintain HIPPA compliance, only sharing your information with other physicians and medical professionals who are assisting with your care, to improve communication and your outcome from treatment. We use a HIPPA compliant Electronic Medical Records. Any communication that we share is done through secure fax or HIPAA compliant email. All documents with your information will be shredded by HIPAA compliant company. You may ask for a copy of your records at any time. If for any reason there is a breach, we are required to notify you. If for any reason you do not want us to share your information or communicate with another healthcare provider or institution, please let us know and we will comply. We will always act in your best interest, never revealing any information that is not necessary during the process of communicating with others.

Printed Name: _____ Date: _____

Signature: _____

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