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 the entire 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 appointments 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 contracted with some insurance companies. Others may or may not have out of network benefits. You as the guarantor are responsible for copays, coinsurance, and out of network charges. Please check with your insurance company to find out if you have out of network benefits. If you have any questions about insurance billing **after** you are seen, contact our **Biller, Traci Barnes 503-978-0178 or traci@tlmedicalbilling.com**

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_____ **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. This includes **All PRP, Stem Cell and Prolotherapy injection treatments,** which are payable at the time of service and are not billed to your insurance. **HSA or Flexible Spending Accounts may be used. We can provide invoices for these services for you.** Auto accident insurances may cover these services, however payment is due up front.

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 ($250)**

Initial_____ **Paperwork** You will be charged an ***additional fee of $25 for paperwork*** we prepare on your behalf***,*** such as completing forms, writing letters, and emailing paperwork that was lost or damaged.

Initial_____ **Referrals** are welcomed to improve communication from your Primary Care Physician. Please provide us with the information we need to communicate with your PCP to ensure continuity of care. This includes a fax number to their office.

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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*_____ Research** We participate in gathering research for most of the injection treatments that are done, which will help determine the best treatment for other patients in the future and will be a way to monitor your benefit from treatment. It would be very helpful if you filled out the questionnaires as they are due over the next months.

***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, 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 Record. Any communication that we share is done through secure fax or HIPPA compliant email. All documents with your information will be shredded by a HIPPA 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.

Initial _____ I give permission to keep my **credit card information** on file. If you choose not to leave credit card info, you will be charged $350 for the initial appointment, and at least $250 for follow up visits (depending on what was done).

Printed Name: _____ Date: _____

Signature: _____ (updated 4/19/21)

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Credit Card on File Authorization

At Musculoskeletal & Sports Medicine we require your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. $350 will be collected for first time appointments and $250 for follow up for patients without insurance benefits. Treatment appointments will be billed based on the price of the treatment.

We provide secured methods of accepting your payment at the time of treatment, and for keeping your credit card on file, to handle any remaining balance after insurance company reimbursement.

I (Guarantor Name) _____

authorize Dr. Jennifer Stebbing DO, to keep my signature and credit card information on file, and to charge my account for balances upon receipt of the EOP (estimate of payment)/EOB (explanation of benefits) from my insurance company.

I understand the provider is offering this as a courtesy, and I may pay my balance in full at any time and cancel this agreement. I am authorizing the use of this card for:

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

Type of Credit Card: _____

Credit Card Number: _____

CVV Code (3 digit code on back of credit card): _____

Expiration Date: _____

Billing Zip Code: _____

Text or Email Receipt: (provide preference): _____

Signature: _____ **Date:** _____

** **YES OR NO -** IS THIS CARD AN (HSA) HEALTH SAVINGS ACCOUNT OR (FSA) FERDERAL SAVING ACCOUNT CARD?

**** YES OR NO** - IS THIS CARD ONLY GOOD FOR THIS CALENDAR YEAR?

(updated 4/19/21)

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Request for Release of Medical Records

I authorize Dr. Jennifer Stebbing DO to disclose or obtain the following information from the health record of :

Patient Name:_____DOB: _____
Address:_____
_____
Phone Number:_____

Please check the items applicable for information to be disclosed. Covering the period(s) of health care from (date)_____to (date) _____.

__Complete Health Records
__History & Physical
__Consultation
__Discharge Summary
__Progress Reports
__Other (specify)_____
__Laboratory Tests
__Xray Reports
__MRI Reports
__Operative Reports
__Procedure Reports
__HIV Results
__Mental Health
__ Drug/alcohol

Please obtain (release) records from (to):
Provider Name: _____
Address: _____
Phone Number: _____Fax:_____

This authorization may be revoked in writing at any time. This authorization will otherwise expire in 2 years time, unless specified otherwise here._____
Your information may be transmitted by fax, electronically or by mail.

Signature_____Date_____

Please send records to:
Musculoskeletal & Sports Medicine c/o Dr. Jennifer Stebbing
Address: 602 NE 3rd Ave, Suite E, Camas WA 98607
Phone: 360-258-1746 Fax 603-373-8094