



Patient Name: _____

Date: _____

POLICIES AND PROCEDURES

Please initial on the line beside each paragraph after reading

_____ **NEW PATIENT INFORMATION:** We appreciate your taking the time to complete all of the enclosed forms and ask that you bring these completed forms to your appointment. It is vital that you also bring a complete list of current medications, including dosages.

_____ **PHYSICIAN OWNED FACILITY:** The physicians listed below are on staff at APM Spine and Sports Physicians (APM), and are also owners of the facility. You may choose to have your procedures and/or therapy at a facility not owned by physicians. By signing below, you acknowledge that you have been informed of this option.

Lisa Barr, MD Scott Horn, DO David Levi, MD Bonnie Nock, DO Robert Spear, DO

_____ **ADVANCED DIRECTIVES:** APM does not honor Advanced Directives. Unexpected complications due to procedures and/or treatment are not natural causes, and therefore, will be treated. This means that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures, and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment, or withdrawal of treatment measures already begun, will be ordered in accordance with your wishes, Advanced Directive, or Health Care Power of Attorney. The admitting facility is not affiliated, or in partnership with APM.

_____ **BLOOD TESTING:** If health care workers are accidentally exposed to my blood or other bodily fluids in the course of providing health care to me, I agree to have my blood tested for any infectious diseases, which might be transmitted to them through this exposure, including HIV/AIDS and hepatitis.

_____ **DRUG TESTING:** All Patients are subject to random drug screens and prescription monitoring

_____ **ATTIRE:** Please wear comfortable clothing. Please avoid wearing lotions, colognes and/or perfumes.

_____ **PREVIOUS MEDICAL RECORDS:** In order to provide you with the highest quality care, the APM physician will need copies of all medical records pertaining to the condition for which you are being treated, including MRI, CT, x-ray and lab reports. We will assist in obtaining these records, but we need your help. Please contact any other physician(s) you have seen for this condition, sign any required releases, and have all relevant records provided to us as soon as possible. These records can either be mailed to our Norfolk office at 5665 Lowery Road, Suite 100, Norfolk, Virginia 23502, in advance of your appointment, or faxed to us at 757-422-1144.

**Please note: if we are unable to obtain your previous medical records prior to your appointment, we may have to reschedule to another date.

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_____ **INSURANCE AND PAYMENT:** Referral from your PCP for your visit, if required, must be obtained in advance from your physician. Should you arrive at APM without the required insurance referral, and still choose to be seen by our doctors, you will be expected to pay 100% of all office charges at the time of visit. This policy applies to all patients. Should you come for a scheduled appointment without the required referral, and subsequently elect to reschedule, a \$25.00 service charge will be added to your account. Insurance does not cover this charge. We accept most major insurances, and will file for insurance benefits as a courtesy to our patients. However, we do expect any co-pay to be paid at the time of your visit. If no payment is received from your carrier within forty-five (45) days of initial filing, you may be asked to pay your balance in full. Please note: Your insurance provider has a contract with you, and you are ultimately responsible for all charges.

_____ **AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS/FACILITY:** I understand that my insurance company may send payments for the rendered services to me. I hereby assign to APM all procedural, medical insurance, and/or other benefits, if any, otherwise payable to me for their services at APM. I agree to endorse the checks over to the facility. I understand that if I use the insurance proceeds for my personal use, I have committed insurance fraud. I hereby authorize and direct payment directly to APM from the obligor of said benefits.

_____ Should you receive a bill from our office, payment in full of the "Patient Balance" is due by the due date indicated, unless other arrangements have been specifically made. Any co-pay and/or fees for non-covered services are due at the time of visit. Payment of all balances is due prior to your next appointment.

_____ For patients involved in legal cases, your account will be billed for any fee-based services requested by your attorney. It is your responsibility to ensure that these charges are paid, either by your attorney or yourself.

_____ **RESCHEDULING/CANCELLING/NO-SHOW POLICY:** In order to ensure that our patients are afforded the most timely and reliable access to our physicians, APM has established a firm policy for "No Shows" and late cancellations. If you fail, without notice, to keep a scheduled appointment, or fail to cancel an appointment with less than 24 hours notice by calling us at 757-422-2966, a \$25.00 charge will be added to your account. Insurance does not cover this charge and it must be paid prior to your being seen again. Please understand that it is our goal to manage our physicians' time wisely, as well as to be courteous to, and caring of, our patients who need our services.

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_____ **RETURNED CHECK POLICY:** We accept cash, money order, checks, MasterCard and Visa as forms of payment. *In the event that a check is returned for insufficient funds, a \$40.00 charge will be added to your account.* If any balance is not paid in full within five (5) business days, the returned check will be forwarded to Gregory D. Underwood, Commonwealth's Attorney for the City of Norfolk, for prosecution. We will no longer accept checks as a form of payment on your account after the second (2nd) returned check.

_____ **COLLECTIONS:** I, _____, hereby authorize APM Spine and Sports Physicians to apply and receive benefits on my behalf for services rendered. I request that payment be made directly to APM Spine and Sport Physicians. I certify that the information provided herein regarding insurance coverage is current, true, and accurate, to the best of my knowledge. I further authorize the release of any necessary medical or other relevant information for this or any related claim to my insurance company(ies) including workers' compensation carriers who either have a pending or accepted case. I permit a copy of this authorization and assignment to be used in place of the original. This will remain in force and effect unless and until revoked by me in writing. I understand and agree that I am financially responsible for all charges whether or not billed to or paid by said insurance. I agree to assume responsibility for all charges incurred should collection of this balance become necessary, including court costs and attorneys fees of 33.33%.

_____ I hereby consent to treatment by the APM physicians , their associates, and/or assistants and accept responsibility for payment of fees for such medical services. I understand that treatment may include injections, manipulation, medication management, medical appliances, and/or other procedures as deemed necessary and appropriate.

The doctors and staff of APM Spine and Sport Physicians are dedicated to excellence in patient care, service and satisfaction. If you have any questions about these policies and procedures, please do not hesitate to ask.

I declare that I have read, understand, and agree to the above policies.

Patient Signature (Parent or Guardian, if under 18)

Date

Witness Signature (Employee/Representative of APM)

Date