Dear_____,

Thank you for choosing Mark Stewart, M.D.! We are committed to the success of your medical treatment and care and look forward to seeing you at your appointment on Date_____ at _____ a.m. p.m.

OFFICE HOURS
Our office is open Monday – Thursday 8:00 a.m. to 4:30 p.m. and Friday 8:00 a.m. to 12:00 p.m. Dr. Stewart is in the office on Tuesday and Thursday.

NO-SHOW/CANCELLATION POLICY
We require 24 hours notice if you find it necessary to cancel your appointment. This is required to allow Dr. Stewart to schedule another patient that needs to be seen in your appointment slot. If 24 hours notice is not given, we reserve the right to charge a $25.00 fee for no show or late cancelled appointments. Please call (989)894-1111 to reschedule your appointment if necessary.

TELEPHONE CALLS
In order to allow Dr. Stewart to attend to his patients with a minimum amount of interruptions, our staff has been instructed to handle all incoming calls.

PRESCRIPTIONS AND REFILLS
Just as we are unable to treat illnesses over the telephone, we cannot prescribe medications over the telephone. Prescriptions and refills are handled only on days that Dr. Stewart is in the office and only if you are currently under his care.

BILLING POLICY
If you have insurance coverage, it is your responsibility to determine eligibility, benefits, and referrals as required. We will file the claims to your primary and secondary insurance companies; however you will be responsible for any copays, deductibles, and/or non-covered services. Payment is due if full upon receipt of your statement. We accept cash, check, VISA, and MasterCard.

WORKER'S COMPENSATION/AUTO INSURANCE
If this is a worker's compensation or auto insurance claim, you will need to obtain authorization from your insurance carrier and provide us with the carrier name, mailing address, claim number, contact person with telephone number, and date of injury. If these items are not available when you come in for your appointment, we will be unable to see you and it will be necessary to reschedule your appointment.

Please be sure to bring the following paperwork along with any x-rays, reports, etc into the office for your appointment.

We will also need you to bring your insurance card(s) to your appointment for the receptionist to copy.

Thank You and we look forward to seeing you soon!

Patient Information

Patient Name: _____Today's Date: _____

Home Address: _____
City, State, Zip: _____
Telephone: Home ( ) _____Cell ( ) _____
Birthdate: _____ Age: _____ Marital Status _____
Email Address: _____May we send information here? Yes No
Occupation: _____ SSN: _____
Employer: _____Years There: _____
Employer's Address:_____
City, State, Zip: _____
Telephone: ( ) _____

Spouse's Name: _____
Home Address (if different than Patient):_____
City, State, Zip: _____
Telephone: Home ( ) _____Cell ( ) _____
Birthdate: _____ Age: _____
Email Address: _____May we send information here? Yes No
Occupation: _____ SSN: _____
Employer: _____Years There: _____
Employer's Address:_____
City, State, Zip: _____
Telephone: ( ) _____

Are you covered by your Spouse's Insurance? Yes No

Complete this section only if someone other than the patient is financially responsible.
Responsible Party: _____Relationship to Patient: _____
Home Address (if different than Patien): _____
City, State, Zip: _____
Telephone: Home ( ) _____Cell ( ) _____
Birthdate: _____ Age: _____ Marital Status _____
Email Address: _____May we send information here? Yes No
Occupation: _____ SSN: _____
Employer: _____Years There: _____
Employer's Address:_____
City, State, Zip: _____
Telephone: ( ) _____

In Case of Emergency, Contact: _____Relationship: _____
Telephone: Home ( ) _____Cell ( ) _____

How did you learn about our practice?_____

Insurance Information

Patient Name: _____Today's Date: _____
[Primary Insurance]
Name of Insurance Company: _____
Insured's Name: _____
Group Number: _____Policy ID Number: _____
[Secondary Insurance]
Name of Insurance Company: _____
Insured's Name: _____
Group Number: _____Policy ID Number: _____

Did your injury happen on the job? Yes No
If yes, on what date did the injury occur?_____
Did you report the accident to your employer? Yes No
Is this visit to be billed to an auto or worker's compensation policy? Yes No
If yes, please list information below:
Name of Insurance Carrier:_____
Contact Person: _____Phone ( )_____
Mailing Address:_____
City, State, Zip: _____
Insured's Name: _____
Claim Number: _____Date of Injury:_____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN:

I hereby authorize Mark C. Stewart, M.D. to release to my insurance company any information acquired in the course of my treatment. This authorization also allows the release of any information to another physician in the event it becomes necessary for you to be referred to another physician. It also allows the release of information to your referring physician, if you were referred by another doctor. This release specifically includes information with respect to communicable diseases or infections, including HIV virus (i.e. AIDS virus).

I further hereby authorize my insurance company to pay directly to Mark C. Stewart, M.D. surgical or medical benefits, if any, otherwise payable to me for services rendered. I understand that amounts deemed by my insurance company to be beyond what they consider "unusual, customary, and/or reasonable charges" for said services will be paid be me. I also understand that I will be liable for any deductible and/or co-payment amounts indicated by my insurance company.

This authorization will remain in effect until revoked, in writing, by me with a copy of the revocation given to Mark C, Stewart, M.D.

Signature of Patient/Responsible Party: _____Date: _____

Patient History

Patient Name: _____ Today's Date: _____

Age:_____ ☐ Male ☐ Female Date of Birth: _____

Height:_____ ☐ Right Handed Date of Injury:_____

Weight: _____ ☐ Left Handed

Family Doctor:_____ Referring Doctor: _____

Reason for today's appointment: _____

Symptoms you have:_____

Have you had any recent x-rays of this area? ☐ Yes ☐ No

If yes, when and where: _____

Medical History: (Circle all that apply)

Anemia	Cancer	Heart Problems	Lung Problems
Stroke	Broken Bones	Diabetes	Hypertension
Pacemaker	Thyroid	Other_____	

Surgical History: (List prior surgeries and dates)

_____ _____ _____

_____ _____ _____

Current Medications:

Name	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to medications: _____

Social History:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Never ☐ Previously, but quit ☐ Current / packs per day _____

Alcohol Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Family History:

Arthritis	Diabetes	Heart Disease	Other _____
Cancer	Lung Disease	Hypertension	

Physician Reviewed:_____ Date: _____

Stewart Orthopedic Financial Policy

Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with our Office Manager, Jennifer Hildebrant.

How May I Pay?
We accept payment by cash, check, VISA, and MasterCard.

Do I Need A Referral?
If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to contact your physician to obtain the referral. If you are unable to obtain the referral at that time, you will be rescheduled.

What Is My Financial Responsibility for Services?
Your financial responsibility depends on a variety of factors, please contact your insurance carrier to find out what your copays, deductibles, and out of pocket costs are.

Surgery
If your physician recommends surgery, you will be working with his Surgery Coordinator. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification and pre-authorization if your insurance company requires it.

What if My Child Needs to See the Physician?
A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Stewart Orthopedic.

I authorize Stewart Orthopedic to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____	_____	_____
Date	**Signature**	**Printed Name**

Mark C. Stewart, M.D.
Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices from Dr. Stewart.

_____ _____

Patient/Legal Guardian Signature Date

Documentation of Failure to Obtain Signed Acknowledgement

On _____, presented its Acknowledgement of Receipt of Notice of Privacy Practices Form to _____. The patient refused or was unable to provide a signature when requested.

_____ _____

Signature of Office Personnel Date