Regenerative Orthopedics Institute, Inc.
E. Renee Smith, M.D.
842 California BLVD
San Luis Obispo, CA 93401
Ph:805-542-9678
Fx:805-542-9685

PATIENT ACCOUNT INFORMATION

Name:_____

Address:_____

_____

Primary Phone:_____ Alt Phone: _____

Email: _____Marital Status: _____

Date of Birth: _____ SSN: _____

Employer:_____Occupation:_____

Employer Address:_____Phone:_____

Primary Physician:_____Referred By:_____

Emergency Contact:_____ Phone:_____

INSURANCE INFORMATION

Insurance Company:_____ Effective Date:_____

ID#: _____ Group#:_____

Guarantor Name:_____ Relationship:_____

Guarantor Address (if different):_____

City:_____ State:_____ Zip:_____

Subscriber_____DOB_____Relationship_____

Subscribers Address_____

Through Employer? No_____ Yes_____ Name_____

Do you carry a 2nd Insurance policy? No_____ Yes _____Carrier:_____

I understand that I, am financially responsible for any and all charges incurred for medical treatment.

Signature:_____ Date:_____

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HEALTH HISTORY

Please indicate past or current medical conditions.

NAME:_____

Medication Allergies: _____

Right handed **Left Handed**

Working **yes** **no** **if no last day you worked** _____
Height_____ **Weight**_____

Location of Problem/Body Part:_____
When incident occurred:_____
What Happened:_____
Doctors seen for this problem:_____
Previous Treatment:___ **X-ray** ___ **MRI** ___ **Bone Scan** ___ **Nerve Test**
___ **Blood work** ___ **Physical Therapy**

	Have you had or do you currently have…	YES	NO		Have you had or do you currently have…	YES	NO
1	Anemia?			17	Stomach ulcers?		
2	Bleeding disorders?			18	Intestinal disease?		
3	High Blood pressure?			19	Kidney disease?		
4	Stroke/TIA/CVA?			20	Elevated cholesterol?		
5	Seizures?			21	Glaucoma?		
6	Coronary artery disease (heart disease)			22	Thyroid disease?		
7	Angina or irregular heartbeat?			23	Osteoporosis?		
8	Diabetes?			24	Rheumatoid arthritis?		
9	Cancer?			25	Osteoarthritis?		
10	Liver Disease/hepatitis?			26	Gout?		
11	COPD (emphysema)?			27	Fibromyalgia?		
12	Asthma?			28	Bone infection/ osteomyelitis?		
13	Bronchitis?			29	Obesity?		
14	Phlebitis (vein problems)			30	Depression?		
15	Peripheral vascular disease?			31	Prostrate Disease/cancer?		
16	GERD?			32	Other(Explain)?		

PREVIOUS SURGERIES: (Please list body part, procedure and date)

_____

_____

_____

_____

ARE YOU CURRENTLY UNDER PAIN MANAGEMENT: **YES** or **NO**
with Whom: _____

MEDICATIONS: (Please list all medications as well as dose and how often you take them).

_____

_____

_____

_____

_____

FAMILY HISTORY: (If you check one please indicate who).

____Diabetes: _____
____Heart Disease: _____
____High blood pressure: _____
____Cancer: _____

DID ANY RELATIVE EVER DIE IN SURGERY? IF SO WHO, AND WHY?

_____

_____

SOCIAL HISTORY:
Marital Status: _____ Children? _____

SUBSTANCE USE: (Please circle YES or NO).

Alcohol? Current: **YES** or **NO** Past: **YES** or **NO**

Please indicate how often and how much_____

Tobacco? Current: **YES** or **NO** Past: **YES** or **NO**

Please indicate how often and how much_____

Smokeless tobacco? Current: **YES** or **NO** Past: **YES** or **NO**

Please indicate how often and how much_____

Vaping other than tobacco? Current: **YES** or **NO** Past: **YES** or **NO**

Please indicate how often and how much_____

Marijuana? Current: **YES** or **NO** Past: **YES** or **NO**

Please indicate how often and how much_____

Illicit drugs? Current: **YES** or **NO** Past: **YES** or **NO**

Please indicate what? _____

Please indicate how often and how much_____

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AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize **E. Renee Smith, M.D.** to obtain any and all medical records pertinent to my care from any physician, hospital, or other healthcare professional.

I also authorize **E. Renee Smith, M.D.** to release any medical records concerning my care to any physician, hospital, or other health care professional. These records include but are not limited to mental health records protected by Lanterman Pertis Short Act, drug and alcohol abuse specifically as follows:

_____

This authorization is effective now and will remain in effect for the time that I am a patient of **E. Renee Smith, M.D.**, or until revoked in writing.

I understand that I have the right to receive a copy of this authorization.

Name:_____ Signature:_____
If not signed by patient please list relationship to patient:_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM:

A copy of the HIPPA guidelines for the office of **E. Renee Smith, M.D.** was made available to me to read at the front desk. Upon request a copy can be made. I understand that due to these guidelines, medical information will only be discussed with me and those listed below. Medical information may include but is not limited to appointments, prescriptions, test results, and chart notes. The office of **E. Renee Smith, M.D.** may leave messages on my answering machine regarding appointments, prescriptions, and phone calls being returned to me.

I AUTHORIZE E. RENEE SMITH, M.D. AND HER STAFF TO RELEASE ANY OR ALL INFORMATION CONCERNING MY MEDICAL CARE TO THE FOLLOWING INDIVIDUALS.

Name:_____ Relationship to Patient:_____
Name:_____ Relationship to Patient:_____
Name:_____ Relationship to Patient:_____
Patient Name: Signature:_____
If not signed by patient please list relationship to patient:_____

Office use only
Patient signed on:_____Witnessed by:_____

I attempted to obtain partient's signature for HIPPA but patient refused
Date:_____Witnessed by:_____

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AGREE AND CONSENT

We are committed to providing you with the best possible care. In order to achieve this goal, we need you to understand and assist us in our payment policy.

Primary Insurance

Co-pays are due at the time of service. All other insurances will be billed as a non-participating provider. If no non-participating provider coverage is available, full payment for services rendered will be due at the time of service.

- A current medical insurance card must be valid to ensure proper billing. Payment will be expected at time of service if insurance cannot be proven to be eligible.
- We are not a Medi-Cal provider. We DO NOT BILL MEDI-CAL.

Secondary Insurance

- We will submit any secondary insurance claims, but not tertiary. If Medicare is primary insurance they will bill your secondary insurance in many cases.

Payments

- All co-pays, co-insurances, deductible charges are due at the time of service.
- Patients without insurance or with an insurance that does not reimburse directly to Dr. Renee Smith are responsible to pay in full at the time of service. We will give you a receipt to submit to your insurance. If you need anything else from our office in order to submit your own claim we will be happy to assist you.

Returned Checks and Collection Procedures

- All returned checks are subject to a $25.00 non-sufficient fund (NSF) fee.
- A $25.00 charge may be applied for missed appointments or for appointments cancelled with less than a 24 hour advance notice.
- Many forms ie: DMV, Disability, FMLA, Life Insurance and record transfers carry a form fee of $15.00
- We reserve the right to forward any past due balance to a third party for collection purposes.

I hereby authorize and give consent to be treated by Dr. Smith and their staff for any examinations, treatment plans or any other medical services. I acknowledge and understand the office policies and procedures explained above and may receive a copy if I need it at any time. I hereby authorize my insurance company to pay Dr. Renee Smith for any services for which I am treated.

Name of Patient:_____

Signature of Patient:_____

Witness:_____

Date:_____

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Understanding insurance and your cost for service

When you choose an insurance plan, you make an agreement with that insurance company that, in exchange for a monthly premium, the insurance company will cover a **portion** of your medical bills. The insurance company will also contract with physicians for special discounts on rates of service and pass those savings on to you.

It is critical that you understand how your own insurance plan works because there are as many plans as there are stars in the sky. We cannot answer these questions for you. Only your insurance company can. However, we have provided a general outline below of how these agreements generally work.

1. We are in-network with most all insurance companies; however **it is your responsibility to verify network status for our facility.**

2. YOU MUST PAY YOUR DEDUCTIBLE EVERY YEAR BEFORE YOUR INSURANCE COMPANY WILL PAY FOR ANYTHING. This means that all medical care you receive prior to meeting that deductible will be paid **by you** until you have met that deductible in full. Luckily, all rates will still be charged at the reduced contracted rate, but **you** will be responsible to pay your medical bills at the time of service until your deductible is met. Deductibles range from a few hundred dollars to several thousand dollars depending on the plan.

3. SEPARATE FROM YOUR DEDUCTIBLE IS **SHARE OF COST PAYMENTS** THAT YOU ARE ALSO RESPONSIBLE FOR. These include **co pays and portion payments.** Information about these payments is often listed on your insurance card and are also determined by your individual plan.

Co pays are your portion of the cost of each visit. You agree to pay this fixed portion of the visit every time. The amount you pay varies with each plan, but is always the same within a plan and it is **due at the time of service.** This is something you agree to do when you sign up with an individual insurance plan.

Ratio payments are also based on your individual plan and come into effect when you have surgery, hospitalizations or major medical testing and other things. You agree to pay a percentage or a ratio of those cost, often 20%. This is in addition to your monthly premium,

deductible and co pays. Again you will pay a portion of the decreased rate that the insurance has contracted for.

When you receive your bill, you will see the actual rates charged by the physician or hospital, and then you will see an amount written off that applies to the contracted decrease which your insurance company has prearranged. You will also see the portion of the fee that your insurance company has paid. Any remaining portion of the fee not paid will be your responsibility to pay. Again this will be based on your individual plan and whether or not you have met your deductible.

Durable medical equipment (braces, splints, walking boots, etc.) may or may not be covered in part or in full, depending on your insurance plan. You will be responsible for whatever your insurance does not cover.

Certain tests including MRI's and most surgeries usually require preauthorization by your individual insurance company. As a courtesy to you, we obtain that authorization. If you do not have preauthorization when required, your insurance company can refuse to pay it's portion of that test or surgery.

If you have more than one insurance company, reimbursement and cost of share can be even more complicated and depend on which companies and which plans. Again we suggest that you make yourself familiar with those plans.

Thank you for taking the time to read this handout. We hope this explanation has been helpful. If you have any questions about what you are required to pay, you should call your insurance company whose number is listed on the back or your card or speak with your insurance representative. It is your responsibility to understand your plan and pay your portion of your healthcare costs as agreed upon by your agreement with you insurance company. We highly recommend that you take the time to understand these issues.

Sincerely,

Dr. Smith and staff

_____	_____	_____
Patients name/party responsible	Patient signature/ party responsible	Date