

## POLICIES

### **Our Commitment to You**

- We will provide you with the most appropriate care in the most time-efficient fashion.
- We will treat you with respect and professionalism.
- We will always do our best to keep your scheduled appointment and to minimize any wait time you may incur. However, due to circumstances beyond our control, there may be times that we must reschedule your appointment with short notice.

### **General Information**

- Our office hours are very limited. It is very important that you keep your appointment.
- If you have an emergency and cannot keep your appointment, you must contact our office **no later than 24 hours** prior to your scheduled appointment date.
- We may charge a **NO SHOW FEE/LATE CANCELLATION** if your appointment is not kept or cancelled 24 hours prior to your scheduled time.
- In order to treat you effectively and efficiently and within HIPAA guidelines, we require a registration form and several other forms be completed by you.

### **Medication Policy**

- It is important to your health that you follow directions carefully on all medications that we prescribe.
- In addition, we must be informed of **ALL** other medications, prescription or over-the-counter.
- We will **NOT** refill **ANY** medication without coming in for an appointment.
- **When a prescription is written, it is expected that the patient return to the office for a follow-up visit prior to continuing that medication. The number of refills written is for that exact purpose and is practicing good medicine.**

**EDUCATION NARCOTIC ALERT:** If you are prescribed a narcotic you will be educated regarding medication side effects and risks. You will also be educated on abuse, addiction, respiratory depression and if overdose, death to the patient. Medication is able to control pain and improve activities of daily living. Patient was educated regarding keeping medication in a safe place, not to use these medications while driving and avoid alcohol. Patient understands and agrees upon it.

### **Financial Policy**

- We expect that you have an understanding of your responsibilities under your insurance contract with respect to referral and preauthorization requirements as well as your deductible, co-pay, and coverage limits.
- Payment is due in full at the time of service, unless you have made payment arrangements in advance with our business office.
- If you have insurance coverage with one of the plans with which we participate, we will bill your insurance company along the guidelines of our contract. However, we require that **all co-pays or deductibles be paid at the time of service.**
- Returned checks will be subject to **an additional \$25 service fee.**
- We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Please realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
- While filing of insurance claims is a courtesy we extend to our patients, all charges are the responsibility of the patient from the date the services are rendered.
- You will be required to show a copy of your insurance card at the time of service. If you do not have your insurance information or we are unable to verify your coverage, you will be required to pay for the services rendered to you that day. If your insurance coverage terminates or changes, you are responsible for notifying us of this change immediately so that we can assist you.

**Missed Appointments**

- Please help us serve you better by keeping scheduled appointments.
- Unless cancelled at least 24 hours in advance, our policy is to charge a NO SHOW FEE for missed office appointments.
- Missed appointments for procedures is a fee of \$100.

**Forms Requiring Physician's Signature**

- Form fee is \$25.00 for initial and \$15.00 for each subsequent.
- Payment is **required** before completed forms are released.
- We require 5-10 business days upon receipt before completion of any form, **NO EXCEPTIONS.**  
**\*\*\*\*Keep in mind it is not our responsibility to obtain forms for you\*\*\*\***

**Referrals To Specialists**

When Dr. Scott gives a referral to another doctor this is not an adequate referral for your insurance company. Dr. Scott sends a referral electronically stating which patients he is sending to an office. If your insurance requires a referral from your primary care physician to see specialists you will need to inform the office. We do not know what each patient's insurance requires and it is not our responsibility to do so. The office requires **3 to 5 business days** to complete a referral as well as the **name, place, date of appointment and NPI number** for that doctor. **Any referrals that are requested in less than 3-5 business days cannot be guaranteed completion** therefore you will need to reschedule your appointment with that doctor.

I HAVE READ the office policies which I UNDERSTAND and AGREE. I also GUARANTEE payment of all charges incurred from my account. I hereby assign benefits to **MARTIN J SCOTT** for all claims submitted to my insurance on my behalf. I further agree to pay any attorney's fee, court cost, and related collection fees incurred.

\_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Patient Name

\_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Witness Name



# M.J. Scott D.O.

*& Associates, PA*

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ SEX: M F  
 If patient is a minor, name of parent or guardian accompanying patient: \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_ Phone # (if different): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home #: \_\_\_\_\_ 2<sup>nd</sup> Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ married single divorced widowed (circle one)  
 Referred by: \_\_\_\_\_ Phone: \_\_\_\_\_ Location: \_\_\_\_\_  
 Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Location: \_\_\_\_\_

**Date of accident: (If applicable):** \_\_\_\_\_ **Type of accident:** \_\_\_\_\_

Please briefly describe the accident. If necessary, you may use the back of this page. Please also note whether you were in the course of employment at the time.

**Primary Insurance Name:** \_\_\_\_\_ Auto Health WC (circle one)  
 Phone #: \_\_\_\_\_ Adj.: \_\_\_\_\_ Ext.: \_\_\_\_\_  
 Claim or ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Subscriber: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Subscriber Date of Birth: \_\_\_\_\_ Subscriber Social Security #: \_\_\_\_\_  
**Secondary Insurance Name:** \_\_\_\_\_ Auto Health WC (circle one)  
 Phone #: \_\_\_\_\_ Adj.: \_\_\_\_\_ Ext.: \_\_\_\_\_  
 Claim or ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Subscriber: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Subscriber Date of Birth: \_\_\_\_\_ Subscriber Social Security #: \_\_\_\_\_  
**Attorney Name:** \_\_\_\_\_ Firm: \_\_\_\_\_  
 Location: \_\_\_\_\_ Phone: \_\_\_\_\_  
**Employer Name :** \_\_\_\_\_ Phone: \_\_\_\_\_  
**Emergency Contact:** \_\_\_\_\_ Phone: \_\_\_\_\_

Are we authorized to release your medical information to the listed emergency contact? Yes or No (circle)

**ACKNOWLEDGEMENT AND UNDERSTANDING**

<p><b>Medical Release</b> – I hereby request and authorize Martin J Scott D.O., to disclose, make available and furnish to:          Company Name: _____          Or his/her authorized representatives all information, records, xrays, reports or copies related to my examination, consultation or treatment and do permit him/her to inspect and make copies or abstracts thereof. I release the doctors, therapists, agents, employee's and any personnel acting on behalf of this office from any and all liability whatsoever pertaining to any use of these records. A photocopy of this form will be valid as the original form</p>	
Patient Signature: _____	Date: _____
<p><b>Records Release</b> – I hereby authorize the release of my records/x-rays/reports or copies of such and request that they be transferred or made available to Martin J. Scott, D.O.</p>	
Patient Signature: _____	Date: _____
<p><b>Consent to Treatment of Minor</b> – I hereby authorize Martin J. Scott, D.O., to render healthcare to my son/daughter as deemed necessary by the physician.</p>	
Patient Signature: _____	Date: _____

## Authorization for Release of Information

Name of Patient _____ Date of Birth _____	
Martin J Scott is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.	
<b>Entity to Receive Information</b> Check each person/entity that you approve to receive information.	<b>Description of information to be released</b> Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays Other: _____ _____
<input type="checkbox"/> Spouse (provide name & phone number) _____ _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____ _____
<input type="checkbox"/> Parent ( provide name & phone number) _____ _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____ _____
<input type="checkbox"/> Other (provide name & phone number) _____ _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____ _____

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**\*Please circle all that apply to help us better understand your medical history\***

**Review of System:**

- Gen             Weight Loss    Weight gain    Fever    Fatigue    Loss of appetite    Nausea    Vomiting
- Skin            Skin problem    Rash    Psoriasis    Slow healing    Easy bruising    Itching
- Neuro          Light headed/dizziness    Fainting    Weakness    Stroke    Tremor    Seizure    Memory loss
- Eyes           Vision problem    Glaucoma    Blurred vision    Double vision
- ENT            Ear pain    Hearing loss    Ear noises    Nose bleed    Sore throat    Hoarseness  
                   Dental problems
- Cardiovascular    Chest pain    Chest pressure    Shortness of breath    Irregular heart beat    Murmurs
- Respiratory      Coughing    Difficulty breathing    Asthma/Wheezing    Coughing up blood
- Gastrointestinal    Constipation    Diarrhea    Heartburn    Bloody stool    Pain in stomach    Ulcers  
                       Hepatitis
- Genitourinary    Painful urination    Frequent urination    Bloody urine    Kidney stone    Incontinence  
                       Loss of libido    Sexual difficulty    Infection
- Endocrine       Hypothyroidism    Hyperthyroidism    Diabetes    Parathyroid problems
- Hematology     Anemia    Bleeding disorder    Easy bleeding    Lymphoma/Leukemia    Sickle cell disease
- Immunologic    Catch cold easily    HIV/AIDS    Fever    Hay fever    Frequent sinus problems    Allergies
- Musculoskeletal    Arthritis    Rheumatoid arthritis    Osteoarthritis    Compression fracture    Head injury  
                       Neck injury    Lower back injury    Spinal trauma    Birth trauma    Birth defect    Lupus  
                       Spina bifida    Gout    Osteoporosis    Muscular dystrophy    Muscle pain    Scoliosis
- Psychiatric     Depression    Anxiety    Panic attacks    OCD    Manic    Bipolar    Suicidal attempts  
                       Hallucination    Other

**Past Medical History:**

- Heart            Coronary artery disease    Hypertension    Murmurs    Valvular disease    Aneurysm  
                       High cholesterol    Pacemaker    Deliberator    Heart failure    Angina    Other: \_\_\_\_\_
- Lungs            Asthma    COPD    Emphysema    Bronchitis    TB    Pneumonia    Lung cancer  
                       Other: \_\_\_\_\_
- Gastrointestinal    Ulcer    Reflux    Gastritis    Hepatitis    Cancer    Bleeding    Diverticulitis  
                       Other: \_\_\_\_\_
- Kidney           Failure    Stones    Dialysis (When): \_\_\_\_\_    Other: \_\_\_\_\_
- Endocrine       Diabetes    Hypothyroidism    Hyperthyroidism    Other: \_\_\_\_\_
- Neuro            Stroke    Aneurysm    Brain cancer    Nerve injury    Spinal cord injury    Alzheimer's  
                       Dementia    Seizures    Parkinson's    Other: \_\_\_\_\_



- Psychiatric     Depression    Bipolar    Anxiety    Panic disorder    Schizophrenia  
 Other: \_\_\_\_\_
- Bone/Muscular    Arthritis    Rheumatoid arthritis    Osteoarthritis    Gout    Osteoporosis    Scoliosis  
 Other: \_\_\_\_\_
- Cancer: \_\_\_\_\_
- Other: \_\_\_\_\_

**Past Surgical History**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies**

- Latex?    No    Yes   Reaction: \_\_\_\_\_
  - Allergic to any medications?    Not that I know of \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Current Medications**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Significant Family History** (Cancer, hypertension, diabetes, depression, back pain...)

- Father's side(specify): \_\_\_\_\_  
\_\_\_\_\_
- Mother's side (specify): \_\_\_\_\_
- Siblings (specify): \_\_\_\_\_  
\_\_\_\_\_

**Social History**

- Tobacco:    Never    Quit in: \_\_\_\_\_    Currently \_\_\_\_\_ pack per day
- Alcohol:    Never    Rarely    Moderate    Daily: \_\_\_\_\_

- Use of drugs:  Never  Occasionally  Frequently, Type/frequency: \_\_\_\_\_
- Marital Status:  Single  Married  Separated  Divorced  Widowed
- Family Status: Living with: \_\_\_\_\_
- Occupation: \_\_\_\_\_
- Disability:  No  Yes (Type): \_\_\_\_\_ Reason \_\_\_\_\_

This form is completed by:

---

**PATIENT'S NAME**

**DATE**