NORTH ALABAMA
BONE & JOINT
CLINIC, P.C.
A STEP AHEAD IN ORTHOPEDIC CARE

Attention Patient:

Thank you for choosing North Alabama Bone and Joint Clinic. Please read all of the information and fill out the enclosed forms prior to your scheduled appointment. Failure to do so **will cause increased wait times or the need to reschedule your appointment for a later time**.

Contact information for our facility is provided below. A map with driving directions is also enclosed in this packet. If you have any questions or are not able to keep your scheduled appointment kindly give us 24 hours notice.

2129 Helton Drive
Florence, AL 35630
Phone: (256) 718-3200
Fax: (256) 246-3297
www.nabjc.com

Hours of Operation: Monday—Thursday 8:00 am—5:00 pm
Friday 8:00 am—4:30 pm

What to bring to your appointment

- A Valid Photo ID
- Current Insurance Card
- Co-pay
  We accept Checks and Debit/Credit Cards including Visa, Discover, MasterCard and American Express.
- Copy of MRI or X-ray, if applicable
- List of Current Medications

*Upon arrival to an appointment, each patient will be asked to review and sign a HIPAA (Health Insurance Portability and Accountability Act) form. This form explains a patient's right to privacy when receiving medical care. Prior to your appointment, consider who, if anyone, you would like to allow access to your medical records. You will be asked to document at check-in.

Attention Medicaid Patients:

All Medicaid patients require a referral from their primary care physician. Please bring this with you to your appointment so that the proper paperwork may be filed in a timely manner.

North Alabama Bone & Joint Clinic, P.C.
PATIENT/CLINIC AGREEMENT

Dear Patient,
All patients being seen in the Outpatient Physical Medicine and Rehabilitation Clinic of North Alabama Bone & Joint Clinic, P.C. must adhere to the following terms.

1. Arrive thirty (30) minutes prior to your scheduled appointment time in order to complete the registration process. Be sure that you bring with you current insurance cards and information.

2. If you are late for your scheduled appointment time, you may not be seen and may be rescheduled for another date and time.

3. As our patient, it is your responsibility to call ahead of time if you need refills on medication that have been prescribed by us. Calls for this purpose are accepted **Monday through Thursday only.** After hours care can be done through your family physician or in medical emergencies through the nearest emergency room.

4. You may be released from the Clinic for reasons including (but not limited to):

    - If you are found to be taking medications other than what we have prescribed or you do not notify the clinic in a timely manner of other or additional medications prescribed by other physicians related to your care.
    - If you miss any scheduled appointments with our Clinic.
    - If you are non-compliant in any treatment plan prescribed (including therapies, medication, or other tests or appointments).
    - If you are verbally abusive or harassing to staff.

5. As our patient, you are responsible to assist us in providing us with all your medical information that may be needed in your care.

6. If you decide that you want to change to another physician, we will be happy to send your medical records to the treating physician.

_____ _____

Patient Signature **Date**

_____ _____

Date of Birth **Patient ID#**

Acct. #_____
(FOR OFFICE USE ONLY)

Rehab and Sports Medicine of the Shoals
Patient Financial Policy

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, or your financial responsibility. If you need further assistance, contact our patient account representative: Donna McCainey, 256-718-3200 ext. 235.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR.

WE WILL ASK TO SEE YOUR INSURANCE CARD ON EVERY VISIT AND WILL SCAN YOUR CARD INTO OUR SYSTEM AS NEEDED TO KEEP OUR INFORMATION CURRENT.

MINOR PATIENTS: Parents are financially responsible for care rendered to their minor child(ren). The adult (parent/guardian) accompanying the minor to the first visit is responsible for any balances not covered by the insurance plan. Minors not accompanied by an adult will be rescheduled if the appointment is non-emergent. If the parent gives written permission to treat without a parent present and the charges have been pre-authorized for payment prior to treatment, then the minor can be treated.

COPAYMENTS: Your insurance REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit.

SELF-PAY: Self-pay accounts shall exist if a patient has no insurance coverage. For new patients, a payment of $200.00 is expected on the day of your appointment before being seen by the health care provider. If you are unable to pay the $200.00, please contact our patient account representative prior to your appointment.

EXTENDED PAYMENT PLANS: Patients are encouraged to pay outstanding self-pay balances in full. However, payment plans may be accepted with the approval of the business office extending payments over a (6) six month period. If you are unable to pay within (6) six months, arrangements with our patient accounts representative must be made.

REFERRALS: If your plan requires a referral from your primary care physician it is your responsibility to obtain it prior to your appointment and to have it with you at the time of the appointment. IF YOU DO NOT HAVE YOUR REFERRAL, YOU MAY BE REQUIRED TO RESCHEDULE.

ACCIDENT/WORKERS COMP CASES: Patients shall be financially responsible for medical services related to accident/workers comp. It is the responsibility of the patient to notify North Alabama Bone & Joint Clinic, P.C. of: date of injury, claim #, insurance company address, phone #, and contact person prior to first treatment for the injury.

MEDICARE: We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the co-insurance, which can be billed to a secondary insurance if you have one.

RETURNED CHECK FEES: Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a fee of $30.00 per check returned. We reserve the right to require future payments to be made by credit card, money order or cash.

AGREEMENT TO PAY & ACCEPTANCE OF PAYMENT POLICY: I, the undersigned, accept the fee(s) charged are due at the time of service. Should it become necessary to forward my account for collection, I agree to pay all monies due, including at 33.33% collection fee, Attorney fees, and/or Court Costs, if such be necessary. I waive now and forever, my right of exemption under the laws of the Constitution of the State of Alabama and any other state. I, the undersigned, give North Alabama Bone and Joint, its employees and agents, express prior consent to contact me at any/all phone numbers, including cell phone numbers, for the purpose of treatment, insurance and/or payment.

I have read this Financial Policy and agree to its terms.

PATIENT COPY

NORTH ALABAMA
BONE & JOINT
CLINIC, P.C.

A STEP AHEAD IN ORTHOPEDIC CARE

Attention: Medicaid Patients

There are ***state required guidelines*** that we must be follow before you or your child can receive care at North Alabama Bone and Joint Clinic.

- **A referral from your Primary Care Physician is required before a doctor can provide treatment. (The Primary Care Physician assigned to you by Medicaid.)**

**If you do not know the name of your Medicaid assigned Primary Care Physician, please call 1 (800) 362-1504. You will need the Medicaid Recipient ID Number and Date of Birth at the time of the call.*

***Please also keep in mind, Alabama Medicaid requires Patient 1st Recipients ages 0-21 to be seen periodically for an EPSDT screening. If your child has not been screened, the state may require a screening with your Primary Care Physician prior to an issued referral at Bone and Joint.*

- **Your Medicaid Card, Current Photo ID and Co-pay are required at the time of your visit.**

We are working hard to continue seeing Medicaid patients in our area and need your participation in getting the proper referral in order to remain a provider.

Thank you.

**Note:*

The Medicaid Agency has established a Recipient Call Center available to assist recipients with questions. For more information or answers to all Medicaid related questions, please call 1 (800) 362-1504.

Patient Survey for Dr. _____

At North Alabama Bone and Joint Clinic, we strive to meet the needs of our patients and their families. Please bring this survey will you to your appointment and complete it during your visit. We care about your experience and continue to strive to remain the leading provider of orthopedic care in Northwest Alabama.

Please circle the number that corresponds with your answer.

1	2	3	4	5
Poor	Fair	Average	Good	Excellent

1. When scheduling an appointment, I was able to see the physician in a reasonable amount of time from my request.	1	2	3	4	5
2. The packet I received answered my questions prior to my appointment.	1	2	3	4	5
3. The access to the office met my needs.	1	2	3	4	5
4. The waiting room and patient areas were clean and free of clutter.	1	2	3	4	5
5. The staff at the front desk were friendly and helpful.	1	2	3	4	5
6. An employee assisted me or provided proper directions to navigate the facility.	1	2	3	4	5
7. The clinical assistant was polite and easy to understand while assisting the physician.	1	2	3	4	5
8. My physician spent an adequate amount of time with me to answer all of my questions.	1	2	3	4	5
9. How would you rate our concern for your privacy?	1	2	3	4	5
10. I would recommend North Alabama Bone and Joint to my family and friends.	1	2	3	4	5

General Comments: _____

_____

_____

Than you for taking the time to complete the patient survey. Please place it in the box at check-out.

_____

Name (optional)