VERO ORTHOPAEDICS NEUROLOGY

THE STRENGTH OF EXPERIENCE

Patient Name: ______________________ DOB: ____________ Date: ____________

Demographics > PCP/Insurance/Pharmacy
Primary Care Physician: ______________________

Pharmacy #1
☐ CVS ☐ Publix ☐ Walgreens ☐ Other: ______________________
Address: ______________________
City: ______________________ State: ____________ Zip: ____________
Phone: ____________ Fax: ____________

Pharmacy #2
☐ CVS ☐ Publix ☐ Walgreens ☐ Other: ______________________
Address: ______________________
City: ______________________ State: ____________ Zip: ____________
Phone: ____________ Fax: ____________

Demographics > Employment
Employer: ______________________ Occupation: ______________________
Employment status: ☐ full-time ☐ part-time ☐ self-employed ☐ unemployed ☐ retired ☐ disabled ☐ child ☐ other:

OBGYN Details
Currently pregnant: ☐ no ☐ yes ☐ possible

Histories > Medical/Surgical/Interim > Medical

☐ Alzheimer's disease
☐ Anemia: ____________
☐ Angina
☐ Arthritis: ____________
☐ Asthma: ____________
☐ Cancer: ____________
☐ Congestive heart failure
☐ COPD
☐ Coronary artery disease
☐ Crohn's disease
☐ Deep venous thrombosis
☐ Degenerative joint disease
☐ Depression
☐ Diabetes: ____________
☐ Drug abuse
☐ Elevated lipids: ____________
☐ Fibromyalgia
☐ Fracture: ____________
☐ Gout
☐ Headache, migraine
☐ Hepatitis/liver disease: ____________
☐ Hypertension
☐ Inflammatory bowel disease
☐ Lyme disease
☐ Myocardial infarction: ____________
☐ Obesity
☐ Osteoporosis
☐ Parkinson disease
☐ Peptic ulcer disease
☐ Psoriasis
☐ Renal disease: ____________
☐ Scoliosis
☐ Seizure disorder
☐ Sleep apnea
☐ Spinal stenosis
☐ Spondyloarthopathy
☐ Stroke
☐ Systemic lupus erythematosus
☐ Thyroid disease
☐ Valvular disease
☐ ____________
☐ ____________
☐ ____________
☐ ____________
☐ ____________

Histories > Medical/Surgical/Interim > Surgical

☐ ACL repair
☐ Amputation: ____________
☐ Angioplasty: ____________
☐ Appendectomy
☐ Arthroscopy: ____________
☐ Back surgery: ____________
☐ Blood transfusion
☐ CABG
☐ Cardiac pacemaker
☐ Cardiac valve replacement
☐ Carpal tunnel release
☐ Cataract extraction
☐ Cholecystectomy
☐ Colectomy
☐ Colostomy
☐ Gastric bypass
☐ Hernia repair
☐ Hip arthroplasty
☐ Hip replacement
☐ Knee replacement
☐ LASIK
☐ Meniscus surgery
☐ ORIF
☐ Rotator cuff surgery
☐ Small bowel resection
☐ Thyroidectomy
☐ Tonsillectomy
☐ ____________
☐ ____________
☐ ____________

Are your injuries related to:
☐ auto accident ☐ work accident ☐ school athletic accident ☐ other accident ☐ none

Attorney: ☐ no ☐ yes (name, phone, address): ______________________

Chief Complaint: ______________________ Date of Injury: ____________
Chief Complaint: ______________________ Date of Injury: ____________
Chief Complaint: ______________________ Date of Injury: ____________

VERO ORTHOPAEDICS NEUROLOGY

THE STRENGTH OF EXPERIENCE

Patient Name: ______________________________ DOB: ______________ Date: ______________

Histories > Family

☐ No relevant family history ☐ Adopted – no family history known

	Relationship:							Onset age:	Cause of death:
☐ ADD/ADHD	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Alcoholism	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Allergies	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Alzheimer's disease	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Anemia	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Arthritis: ____________	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Asthma	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Blood disorder	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Cancer: ____________	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Cardiovascular disease: ________	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Colitis	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Congenital heart disease	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Congestive heart failure	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ COPD	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Coronary artery disease	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Coronary artery disease, premature	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Depression	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Developmental delay	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Diabetes: ____________	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Drug abuse	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Elevated lipids: ____________	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Genetic disease	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Gout	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Hearing impairment	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Hypertension	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Learning disability	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Liver disease: ____________	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Mental illness	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Migraines	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Muscle disease	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Obesity	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Osteoporosis	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Parkinson's disease	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Peripheral vascular disease: ________	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Renal disease	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Seizure disorder	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Stroke	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Thyroid disorder	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Other: ____________	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Other: ____________	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Other: ____________	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Other: ____________	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐
☐ Other: ____________	☐ Mother	☐ Father	☐ Daughter	☐ Son	☐ Sister	☐ Brother	☐ Other: ________	____	☐

VERO ORTHOPAEDICS NEUROLOGY

THE STRENGTH OF EXPERIENCE

Patient Name: ______________________________ DOB: ______________ Date: ______________

Histories > Social > Tobacco > Tobacco Use

Tobacco Use

Have you ever used tobacco? ☐ no/never ☐ yes

Smoking Tobacco Use

Tobacco type:

☐ Cigarette Age stopped: __________

☐ Cigarillo Age stopped: __________

☐ Cigar Age stopped: __________

☐ Pipe Age stopped: __________

Non-Smoking Tobacco Use

Tobacco type:

☐ Chewing Age stopped: __________

☐ Smokeless Age stopped: __________

☐ Snuff Age stopped: __________

Histories > Social > Alcohol/Caffeine

Alcohol

Do you drink alcohol? ☐ no ☐ yes ☐ formerly

Frequency: ☐ daily ☐ weekly ☐ monthly ☐ rarely ☐ socially

Caffeine

Do you drink/consume caffeine? ☐ no ☐ yes: ______ cups per day

Histories > Social > Statuses

Demographics

Hand Dominance: ☐ right ☐ left ☐ ambidextrous

Marital Status/Family/Social Support

Current Status: ☐ married ☐ single ☐ divorced ☐ widow ☐ ____________

Histories > Social > Lifestyle

Lifestyle

Activity level: ☐ sedentary ☐ moderate ☐ vigorous

Type of exercise: ☐ aerobic ☐ baseball/softball ☐ cycling ☐ golf ☐ running ☐ tennis ☐ yoga ☐ other: ____________________

Exercise frequency: ☐ 2 – 3 times/week ☐ 3 – 4 times/week ☐ daily ☐ never ☐ occasional

Intake > Vital Signs

Height/length measurements: ______ ft. ______ in. Weight measurements: ______ lb.

Pain scale (please circle with 1 being no pain and 10 being worst pain) 1 2 3 4 5 6 7 8 9 10

☐ No medications **PLEASE PROVIDE MEDICATION LIST IF NEEDED**

Name	Dosage	Frequency	Route
______	______ mg	______	☐ oral ☐ topical ☐ ______
______	______ mg	______	☐ oral ☐ topical ☐ ______
______	______ mg	______	☐ oral ☐ topical ☐ ______
______	______ mg	______	☐ oral ☐ topical ☐ ______
______	______ mg	______	☐ oral ☐ topical ☐ ______
______	______ mg	______	☐ oral ☐ topical ☐ ______
______	______ mg	______	☐ oral ☐ topical ☐ ______
______	______ mg	______	☐ oral ☐ topical ☐ ______
______	______ mg	______	☐ oral ☐ topical ☐ ______
______	______ mg	______	☐ oral ☐ topical ☐ ______

VERO ORTHOPAEDICS NEUROLOGY
THE STRENGTH OF EXPERIENCE

Patient Name: ______________________ DOB: ____________ Date: ____________

Intake > Allergies

☐ No know allergies

☐ Accupril (Quinapril)
☐ Acetaminophen
☐ Acyclovir
☐ Advil (Ibuprofen)
☐ Altace (Ramipril)
☐ Ampicillin
☐ Amaryl (Glimepiride)
☐ Augmentin (Amoxicillin)
☐ Aspirin
☐ Bactrim (Sulfamethoxazole)
☐ Biaxin
☐ Carafate (Sucralfate)
☐ Ceclor (Cefaclor)
☐ Celebrex
☐ Cephalosporins
☐ Cipro (Ciprofloxacin)
☐ Clinoril (Sulindac)
☐ Contrast media (Ioversol)
☐ Codeine
☐ Coumadin
☐ Darvon
☐ Demerol
☐ Depakote
☐ Diabeta (Glyburide)
☐ Diamox
☐ Dicloxacillin
☐ Doxyclycline
☐ Egg
☐ Erythromycin
☐ Famotidine
☐ Flagyl
☐ Floxin
☐ Glucotrol (Glipizide)
☐ Heparin
☐ Iburofen
☐ Inderal (Propranolol)
☐ Indocin (Indomethacin)
☐ Insulin (Animal)
☐ Iodine or shellfish
☐ Keflex (Cephalexin)
☐ Klonopin
☐ Lasix (Furosemide)
☐ Latex
☐ Levofloxacin
☐ Lidocaine
☐ Lipitor
☐ Lodine
☐ Lopressor (Metoprolol)
☐ Micronase (Glyburide)
☐ Minocin (Minocycline)
☐ Morphine
☐ Motrin (Ibuprofen)
☐ Naprosyn (Naproxen)
☐ Neptazane
☐ Niacin
☐ Oxycodone
☐ Peanut
☐ Penicillin
☐ Percodet (Oxycodone)
☐ Persantine
☐ Plavix
☐ Phenytoin
☐ Pravachol
☐ Prevacid
☐ Prilosec
☐ Prinivil
☐ Quinolones
☐ Ranitidine
☐ Septra (Sulfamethoxazole)
☐ Sulfa
☐ Tagamet (Cimetidine)
☐ Tegretol (Carbamazepine)
☐ Tenormin (Atenolol)
☐ Tetanus toxoid
☐ Tetracycline
☐ Ticlid
☐ Valium (Diazepam)
☐ Vancomycin
☐ Vasotec
☐ Zestril
☐ Zithromax
☐ Zocor (Simvastatin)
☐ Zyloprim (Allopurinol)
☐ ____________________

Review of Systems

Report *positive* symptoms by checking the respective box(es).

Constitutional: ☐ fatigue ☐ fever ☐ night sweats ☐ other: ____________

Eyes: ☐ vision loss ☐ glasses ☐ contacts ☐ LASIK ☐ other: ____________

Repiratory: ☐ cough ☐ shortness of breath (dyspnea) ☐ wheezing ☐ other: ____________

Cardiovascular: ☐ chest pain ☐ irregular heartbeat/palpitations ☐ other: ____________

Gastrointestinal: ☐ constipation ☐ diarrhea ☐ nausea ☐ vomiting ☐ other: ____________

Genitourinary: ☐ painful urination (dysuria) ☐ blood in urine (hematuria) ☐ urinary incontinence ☐ other: ____________

Endocrine: ☐ cold intolerance ☐ heat intolerance ☐ other: ____________

Neurovascular: ☐ dizziness ☐ headache ☐ other: ____________

Integumentary: ☐ rash ☐ skin lesion ☐ other: ____________

Hematologic/Lymphatic: ☐ easy bleeding ☐ bruising ☐ other: ____________

Allergic/Immunologic: ☐ environmental allergies ☐ food allergies ☐ other: ____________

VERO ORTHOPAEDICS NEUROLOGY

THE STRENGTH OF EXPERIENCE

Authorization to Release Health Information

Vero Orthopaedics & Neurology is willing to assist you in receiving your protected health information. In order to do this, you must authorize us to provide this information to persons (other than physicians) by completing this form.

By authorizing the listed persons below, they will have access to any and all of my health information, up to and including HIV, drug and alcohol, and psychiatric records. Vero Orthopaedics & Neurology is permitted to release this information to the following:

Persons (other than physicians) authorized to receive my medical information:

- Name: ________________________ Relationship: ______________ Phone: ______________
- Name: ________________________ Relationship: ______________ Phone: ______________
- Name: ________________________ Relationship: ______________ Phone: ______________

You may notify me or the parties listed above with normal test results, appointment reminders, and other information regarding my health information as follows:

_____ Message on answering machine. Phone number: ______________________________

_____ Message on work voicemail. Phone number: ______________________________

_____ Message on cell phone. Phone number: ______________________________

_____ Other. Phone number: ______________________________

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

Patient Signature: ____ Date: ________________

PLEASE BE ADVISED WHEN PICKING UP ANY PAPERWORK OR PRESCRIPTIONS FROM YOUR DOCTOR YOU MUST PRODUCE YOUR DRIVERS LICENSE FOR VERIFICATION. IF YOU NEED SOMEONE OTHER THAN YOURSELF TO PICK UP YOUR PAPERWORK OR PRESCRIPTIONS THEY MUST BE LISTED ON THIS FORM.

I UNDERSTAND THE STATEMENT ABOVE AND ENSURE ALL PARTIES THAT ARE LISTED CAN PICK UP PAPERWORK OR OBTAIN MY PRESCRIPTION MEDICATIONS.

PATIENT SIGNATURE: ____

VERO ORTHOPAEDICS NEUROLOGY

THE STRENGTH OF EXPERIENCE

HIPAA: This organization complies with all HIPAA and other federal privacy regulations. A notice of privacy policies is available upon request. I acknowledge by signature below that I have been made aware of my right to review or obtain a copy of the policies.

NOTICE OF HEALTHCARE INFORMATION: All patient records remain the property of this practice. Records are centralized and may be accessed by the medical providers or employees as a necessary function of their role within the organization. This organization does not release patient records unless necessary for purposes of medical treatment, obtaining payment, or supporting the day-to-day healthcare operations of the practice. Patient signature below provides the practice your consent to use and disclose my health information in accordance to above statement.

AUTHORIZATION FOR RELEASE OF RECORDS: With my signature below, I consent to medical, surgical care, and treatment as may be deemed necessary or advisable in the judgment of my doctor and other providers. Such medical and surgical care and treatment may be performed at any organizational facility, including emergency treatment or services, and may include, but is not limited to lab procedures, X-rays, medical and surgical treatments or procedures, and medical administration, including but not limited to immunizations and injections.

PARTICIPANTS IN MEDICARE PART B: My signature below allows for the holder of medical or other information about me to be released to the Social Security Administration and the CMS First Coast SVC Optional or its intermediaries or carriers, or the billing agent of this organization, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment.

INSURANCE AUTHORIZATION: By signing this agreement, I assign the benefits payable for doctor services to the doctor and organization furnishing the services and authorize them to submit a claim to my health insurance as needed for payment of services. I authorize any holder of medical or other information about me for release to my insurance carrier that is needed for this or a related claim.

I have been advised that payment is due at time of service. I understand that I will receive itemized statements of my account reflecting the balance pending with insurance and due from me. It remains the responsibility for final payment on my account, regardless of the payment or lack of payment by my insurance carrier. I accept these arrangements while continuing to receive care and services. I also understand that I am responsible in notifying this office when there are changes to my insurance. This authorization and assignment is to be a continuing one, remaining in force until revoked in writing by the undersigned. I also agree that the information below is correct.

Patient Signature: ____

Patient Name: ______________________ D.O.B ______________________

Address: ____

Primary Insurance: ____

Secondary Insurance: ____

____

(Signature of parent/trustee/guardian if patient is a minor)

VERO ORTHOPAEDICS NEUROLOGY

THE STRENGTH OF EXPERIENCE

Financial Policy

Thank you for choosing Vero Orthopaedics & Neurology for your orthopaedic and neurological care. Our doctors and staff are committed to providing quality and affordable medical care. We sincerely hope that by sharing our financial expectations we will strengthen the practice-patient relationship and keep the lines of communication open. This financial policy helps the practice provide quality care to our valued patients. If you have any questions or need clarification of any of the policies, please feel free to contact our Business Office at (772) 569-2330.

As a patient of Vero Orthopaedics & Neurology, you are required to sign a financial responsibility and authorization for treatment form.

All appointments require a 24-hour cancellation notice. Please be aware that if you do not show for your appointment, there will be a $25.00 fee. This is not reimbursed by insurance plans.

Payment Is Due at the Time of Service

- All Self-Pay patients and patients who present without proof of insurance should be prepared to pay $100 – $300 in cash, check, money order, or credit card at the time of check-in on initial and follow-up appointments. Additional charges may be incurred for testing, supplies, and casting.
- We accept cash, checks, and debit and credit cards.
- All copayments, deductibles, and non-covered services are due at the time of service.
- Insurance required copayments are due when you check in for your appointment. If you arrive without your copayment, we may ask you to reschedule.
- If your copayment is based on a percentage (example: 20% of the allowed payment) and you do not have a secondary policy, please be prepared to pay a minimum of $20.00 on the date of service.
- Patient-responsible balances are due when you check in for your appointment.
- In the event you need surgery and you do not have health insurance coverage, we must receive 100% of the estimated doctor's fees before we will schedule the surgery.
- Any past due balances on account or accounts placed with a collection agency must be paid in full prior to any further services.

Proof of Insurance

- Please bring your insurance card(s) with you to each appointment.
- Vero Orthopaedics & Neurology providers do not participate in any HMO plan.
- It is your responsibility to inform the reception staff when the cause of treatment may be the responsibility of a third party—auto insurance, liability insurance company, worker's compensation—instead of your regular health insurance carrier. You are responsible to provide the office with all information required to bill the third party when you schedule your appointment.
- You have a contract with your insurance company to receive benefits. It is your responsibility to be knowledgeable of your benefits. We are happy to submit claims for you, but the patient is ultimately responsible for payment for any charges incurred.
- It is your responsibility to notify the practice of changes in your health insurance.
- On occasion, your insurance may determine the care you have received is NOT a covered benefit. For instance, DME, MRI, and physical therapy are sometimes processed as "out of network" or "not medically necessary" and costs may revert to you directly on the carrier's Explanation of Benefits. You are responsible to pay these charges if that happens. Please read your insurance handbook and be aware of what your insurance offers for benefits. Contact your insurance company directly for clarification. You are responsible for care not covered by your insurance plan.

- NON-PARTICIPATING INSURANCE PLANS: As a service to our patients, Vero Orthopaedics & Neurology will bill as a non-participating claim. All outstanding balances are the responsibility of the patient. If you elect to be treated by any doctor or therapist or any provider at Vero Orthopaedics & Neurology who does not participate in you insurance plan, you will be responsible for payments.
- If your insurance 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 or prior to. If you do not have your referral, you may have to reschedule your appointment.

Billing, Payments, and Refunds

- All balances are due in full within 14 days of the statement date.
- If you cannot pay the balance in full within 14 days, please contact our billing office at (772) 569-2330.
- It is your responsibility to notify the office of any change in address, phone, or insurance coverage.
- We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this practice. In accounts placed with the credit bureau, balances must be paid in full prior to any further services.
- Any returned check from the bank for non-payment or insufficient funds shall result in the patient's account being assessed a $25.00 fee per check returned.
- An option to apply for a healthcare credit card is available. You may inquire with the billing staff of how to apply. The company associated with this service is called CareCredit.
- CHILD CUSTODY CASES and SECOND PARTY INSURANCE: Vero Orthopaedics & Neurology will bill the insurance carrier for both parents. However, the parent that signs for services will be responsible for all outstanding charges and balances unless you have a court order otherwise, with name, address of responsible party.
- FRACTURE CARE: Some insurance companies require that fracture care billing be done on a global basis. This means that for a predetermined amount of time, all professional services related to the surgery or fracture care are included within the initial fee. X-rays and casting/splinting, along with related supplies, are not included within the global fee and are billed separately. Please note, there are other insurance companies that require each visit to be billed separately.
- Injections, joint aspirations, and fracture care are all procedures listed as "surgical" for billing purposes by insurance companies. Though these services may be provided in the office or emergency room, they are generally listed on your Explanation of Benefits or bill as "surgical."
- Third-party forms (i.e. disability, FMLA, etc.): There is a charge of up to $10.00 per page for completing forms by a doctor. Prepayment is required. Patient information portion of the form must first be completed.

I have read the Financial Policy of Vero Orthopaedics & Neurology and agree to abide by its terms.

______________________________ ____________________

Patient Name (Print Please) Date of Birth

______________________________ ____________________

Patient (or Representative Guardian Parent) Signature Date

Vero Orthopaedics & Neurology complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.