Dr. H. Kurtis Biggs, DO
Dr. Brian Wallace, DO
Dr. Jamie Weaver, DPM

Welcome to the Joint Replacement Institute

The Joint Replacement Institute is committed to providing personalized orthopedic care combined with state of the art surgical procedures for unparalleled outcomes. The receptionists, nurses, and technical personnel of J.R.I., work as a team to provide high quality service and pride themselves in their communication skills and compassion.

We thank you for choosing Joint Replacement Institute. You are encouraged to review the information provided here as well as visit our website at jointinstitutefl.com for additional material about the practice and educational information.

Financial Information:

We make every effort to decrease the cost of your healthcare. Therefore, we require payment for all services at the time they are rendered. We accept cash, checks, Mastercard, Visa, American Express and Discover for your convenience. If we are a participating provider of your insurance, we will bill them. However, payment is the patient's responsibility. We will help in any way we can to assist you in handling your claim.

All payments are due at time of service. All co-pays will be collected prior to your appointment. All deductibles & coinsurance will be collected prior to surgical services. Failure to cancel appointment more than 24 hours prior will result in an office charge as it limits the ability to provide service to another patient.

Prescription Refills:

Please request all medication refills during normal business hours Monday through Thursday 8-5 and Friday before noon. **If a request is called in after noon the refill will be taken care of within 24-48 hours**. No narcotic medications will be refilled after hours or on the weekend as there is no access to patients charts to safely provide medication administration.

After Hours Care:

Patients can call 239-261-2663 24 hours a day to contact the office or leave a message. Specific instructions for after hours care is provided there or go to jointinstitutefl.com for further details. If it is an emergency call 911.

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Patient Registration Form

METHOD OF PAYMENT ☐ Cash ☐ Check ☐ Visa/Mastercard/Discover

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Address _____ Billing Address? ☐ yes ☐ no

City _____ State _____ Zip _____ Home Phone _____ Day Phone _____

Alternate Address _____

City _____ State _____ Zip _____ Alternate Phone _____

Birth Date _____ ☐ Male ☐ Female ☐ Single ☐ Married Social Security # _____

E-mail address_____

CHIEF COMPLAINT TODAY_____

WHO IS YOUR PRIMARY CARE PROVIDER?_____

HOW WERE YOU REFERRED TO US? _____

RESPONSIBLE PARTY Relationship to Patient _____

Bill to First Name _____ Middle Initial _____ Last Name _____

Billing Address _____

City _____ State _____ Zip _____ Contact Phone _____ Time of Day _____

Social Security # _____ Birth Date _____

Please be advised that we are unable to bill any insurance accepted by our office without a copy of the current insurance card. Also, in the event your insurance company denies the claim for ANY reason, you will be personally responsible for the charges incurred.

SURGERY CANCELLATION POLICY

A fee of $250.00 will be charged if a cancellation for a scheduled surgical procedure is less than 48 hours notice.

_____
Signature

OFFICE VISIT CANCELLATION & NO SHOW POLICY

A fee of $50.00 will be charged if a cancellation for a scheduled office visit is given less than 24 hours notice from the appointment time.

_____
Signature

ADDITIONAL OFFICE CHARGES

A minimum of $10.00 fee will be charged on CD's with x-rays or any paperwork packet that requires the providers additional time. $50.00 additional fee for returned checks.

_____
Signature

ASSIGNMENT OF BENEFITS

I authorize assignment of all medical insurance benefits to the named provider for medical services rendered.

_____
INITIALS

ASSIGNMENT TO PAY FOR SERVICES

I agree to pay Joint Replacement Institute for all charges for services rendered today, or any future date of service, in this office. I understand payment in full **and/or** co-pay **and/or** co-insurance is expected at the time services are rendered. I further understand, in the event this account is referred to an agency or attorney for collection, I will be responsible for all collection fees, attorneys' fees and/or court costs.

_____
INITIALS

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Patient Affordable Care Act

As your health care provider, Joint Replacement Institute, (JRI) has important information to share with you regarding recent changes in the Patient Affordable Care Act (PACA).
One of the new regulations requires providers who utilize electronic health records (EHR), as JRI proudly does, to request additional personal information from our patients and to report this information to the Center for Medicare and Medicaid Services (CMS). Specifically, we are to ask our patients to indicate "Race" and "Ethnicity" as part of the patient profile and then we are to submit a report annually that indicates the percentage of each "Race" and "Ethnicity" that comprise our practice**. No individual or private health information will be included in this report.**

Please note that the information you provide will have no impact on the health care you receive from our JRI providers and staff as our team is committed to providing access to quality physicians and services to all of our patients.

Although your participation is not mandatory, we would appreciate your taking a moment to answer the questions below and return this form to a member of our front office staff. The staff will update your electronic health records at that time.

Patient Name:	**Patient Date of Birth:**
Please mark the answer that best describes your ethnicity:	□ Hispanic or Latino □ Not Hispanic or Latino □ Decline to answer
Please mark the answer that best describes your race:	□ American Indian or Alaska Native □ Black or African American □ Asian □ Native Hawaiian or Other Pacific Islander □ White □ Other _____ □ Decline to Answer
Please indicate your Preferred Language:	□ _____ □ Decline to Answer

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Joint Replacement Institute for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Joint Replacement Institute. I understand that diagnosis or treatment of me by a **Joint Replacement Institute Provider** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Joint Replacement Institute** is not required to agree to the restrictions that I may request. However, if **Joint Replacement Institute** agrees to a restriction that I request, the restriction is binding on **Joint Replacement Institute** and **it's Healthcare Providers**. I have the right to revoke this consent, in writing, at any time, except to the extent that **Joint Replacement Institute** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Joint Replacement Institute's** Notice of Privacy Practices prior to signing this document. The **Joint Replacement Institute's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Joint Replacement Institute.** The Notice of Privacy Practices for **Joint Replacement Institute** is also posted in the Patient Waiting Rooms. This Notice of Privacy Practices also describes my rights and the **Joint Replacement Institute's** duties with respect to my protected health information.

Joint Replacement Institute reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have read and had the opportunity to have a copy of **Joint Replacement Institute's** Right to Privacy Statement.

_____ _____

Signature of Patient or Personal Representative's Authority Date

Us HIPAA02-1/2/03

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Pharmacy Information

Patient Name: _____ DOB: _____

Name of Pharmacy: _____

Pharmacy Phone Number: _____

Pharmacy Address or cross-street: _____

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Notice of Disclosure

Dr. Biggs & Dr. Weaver have an investment interest in Divine Pharmacy, 2815 US 19 Alt, Palm Harbor, FL 34683, which provides compounded pharmaceuticals. Patients are free to obtain products from this entity or any other provider. Including the local providers listed below, or any entity not provided on this list.

Soothe Pharmacy
1824 50th Street West
Bradenton, FL 34209
P: 855-776-6843

Institutional Pharmacy Solutions
2697 International Parkway
BLDG 3, Suite 104
Virginia Beach, VA 23452
P: 855-297-9788
F: 877-327-0220