THE ORTHOPEDIC CENTER OF ST. LOUIS

14825 North Outer 40 Road
Chesterfield, Missouri 63017

Welcome to The Orthopedic Center of St. Louis. It is our mission to provide patient-centered medical care by partnering with our patients to manage pain and foster an overall healthy lifestyle. Dr. Reeves provides exceptional medical care and, in the spirit of partnership asks his patients to become active participants in developing and working the individual treatment plan.

Your packet contains general information about our office policies and procedures, as well as several forms for you to complete and return to the office on the day of your appointment.

- ☐ Please plan to arrive at your appointment no less than 15 minutes prior to your scheduled time. This will allow plenty of time of complete your registration.

- ☐ Bring a photo ID and, if you are covered by private or group health insurance, your insurance card. Although you may have an active worker's compensation case, we need to have your health insurance information on file in the event the claims are denied by worker's compensation.

- ☐ If you have had any imaging studies related to your pain problem, we ask that you bring a disc with the images to the appointment. If you do not have the disc on your appointment date, we may ask you to reschedule your appointment. You may reach out to your case manager, or case adjuster, for assistance in obtaining this disc.

We look forward to working with you to achieve your healthcare goals and encourage you to call the office if you have any questions about the information contained in this packet.

APPOINTMENT DATE: _____

APPOINTMENT TIME: _____

THE ORTHOPEDIC CENTER OF ST. LOUIS
14825 North Outer 40 Road, Suite 200
Chesterfield, Missouri 63017

PRACTICE INFORMATION

Because we value open communication and mutual respect, we created this Practice Information Guide to help make your visits here convenient, pleasant, and beneficial.

Office Hours

- Our office is open from 8:00 until 5:00 Monday through Friday.
  The phone number is: 314-336-2555; we accept telephone calls beginning at 8:00 until 5:00.

After Hours and Emergency Care

- If you experience a life-threatening medical condition after office hours, call 911 or go immediately to the nearest Emergency Department, even if you are out of town.
- If you have an urgent medical concern that cannot wait until the office reopens, you may reach our doctors through our answering service: 314-995-0891.
- Reminder: the doctors will not authorize refills of maintenance medications after office hours.

Appointments

- We strive to minimize wait times and to spend as much time as needed to address your medical concerns. For this reason, we see our patients by appointment and strongly discourage walk-in visits.
- We room patients in appointment-time order. Expect the doctor to treat the primary reason for the scheduled office visit. We may ask you to schedule another appointment to address concerns other than the primary reason for your visit.
- If you arrive LESS than 15 minutes before your scheduled appointment time, we will do our best to assist you; however, we may ask you to reschedule.

Medication Refills

- We make every effort to process prescription refill requests as quickly as possible. Please allow **48-72 hours** for our staff to process your refill request.
- To ensure you do not run out of medication, ask your pharmacy to fax the refill request to **833-365-7948** no less than three (3) days before you need it.
- Dr. Reeves will only authorize prescriptions for narcotic medications during office hours; his Medical Assistant may ask you to schedule an office visit before authorizing your refill request. **Dr. Reeves will not prescribe any narcotics unless surgery is warranted**.

Personal Health Information

- Each physician reserves the right to determine the type of medical-care-related forms they will complete and sign.
- **FMLA and STD Forms will only be completed for surgery and will only be completed when a surgical date is scheduled. Please fax forms to 833-365-7948. Please allow 10 business days from the date we receive the request to complete the forms.**
- Our practice has a medical record department to process requests for medical records. We must have a signed, HIPAA-compliant authorization to release copies of your medical records. Please find the form on www.toc-stl.com and go to patient forms at the top. Then click on Medical Record Release.
  Please allow no less than ten (10) business days from the date we receive the request to process these requests.

Registration / Insurance

- Please review insurance information with our staff *prior* to receiving care to make certain your doctor is a contracted provider for your plan.
- We expect you present a valid insurance card and photo ID at each visit, even if you have an active workers' compensation claim.
- Please tell the staff member at check-in if you have any change in insurance, contact information, address, or pharmacy preference

Patient Signature:_____ Patient Name (print):_____ Date: _____

DR. CHRIS R. REEVES

PATIENT REGISTRATION

FIRST NAME	MIDDLE NAME/INITIAL	LAST NAME

Preferred Name	Date of Birth	Social Security Number	Gender: Male ☐ Female ☐

Primary Care Doctor	Name	Address	Phone	Fax
Referring Provider	Name	Address	Phone	Fax

DEMOGRAPHIC INFORMATION

Home Address							Zip code
Home Phone	Area code	Number		Work Phone	Area code	Number	Extension
Cell Phone	Area code	Number		Preferred Phone	Home ☐	Work ☐	Cellular ☐
Email Address				Preferred communication	Phone ☐	Mail ☐	Email ☐
Mailing Address *(if different from home address)*-							Zip code
Whom shall we contact in an emergency?				Relationship to patient?			Phone number
Race				Ethnicity:	Hispanic/Latino ☐	Non Hispanic/Latino ☐	Unreported/Refused ☐
Preferred Language	English ☐	Spanish ☐	Other ☐	Do you need an interpreter? What type of interpreter?	Yes ☐	No ☐	
Marital Status	Single ☐	Married ☐	Divorced ☐	Widowed ☐	Domestic Partner ☐		
Employment	Full-Time ☐	Part Time ☐	Not Employed ☐	Student ☐	Employer		

PRIMARY INSURANCE

Insurance Plan Name		Effective Date	
Subscriber ID		Group Number	
Insured's Name		Date of Birth	
Relationship to Patient	Self Spouse Parent Partner	Social Security #	

SECONDARY INSURANCE

Insurance Plan Name		Effective Date	
Subscriber ID		Group Number	
Insured's Name		Date of Birth	
Relationship to Patient	Self ☐ Spouse ☐ Parent ☐ Partner ☐	Social Security #	

ASSIGNMENT OF BENEFITS

- I understand I am financially responsible for all charges and services provided to me, including the balance remaining after payment of potential insurance benefits. I authorize payment of medical insurance benefits to The Orthopedic Center of St. louis for professional services rendered.
- I authorize the release of any information necessary to process this claim.
- I certify that all the above information is true and correct to the best of my knowledge. I give my permission to the Provider and/or medical staff to administer and perform such procedures deemed necessary in the diagnosis and/or treatment of my medical condition(s).

Signature of Patient / Legal Guardian/Representative	Relationship	Date

EXTENDED INFORMATION

Date of Injury	
How were you injured?	
If you were involved in a Motor Vehicle Accident, in what state did it occur?	

WORKERS' COMPENSATION INFORMATION	
Insurance Company Name	
Claim Number	

Case Adjuster	
Office Phone	
Office Fax	
Email Address	
Mailing Address	
City / State / Zip	

Case Manager	
Office Phone	
Office Fax	
Email Address	
Mailing Address	
City / State / Zip	

ATTORNEY			
Attorney's Name			
Name of Firm			
Mailing Address			
City / State / Zip			
Office Phone		Office Fax	
Email Address			

AUTHORIZATION FOR MEDICAL TREATMENT and RELEASE OF INFORMATION

I authorize my physician and his/her employees, to provide the medical care, tests, procedures, medications, services and supplies considered advisable by my physician. These services may include pathology, radiology, emergency and other special services. In consenting to treatment, I have not relied on any statements as to results. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any of antibodies to hepatitis A, B, and C and HIV.

STORAGE AND RELEASE OF INFORMATION

I consent to the electronic storage and transmission of patient health information. I hereby authorize my treating physician, to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to:

a. Any governmental or other entity as required by law for purposes of reporting or for purposes of determining the eligibility in government sponsored benefit programs.
b. The supplier of any blood or blood products which may be administered to me for the purposes of quality control and recipient monitoring.
c. Any continuing care, residential or long-term care facility, or home health agency for the purposes of providing services for my care.
d. Another health care provider that prescribes medication electronically to provide continuity of care and quality of care issues regarding prescriptions.
e. I also authorize my physician to obtain information from other providers regarding my care and treatment including obtaining my electronic medication and prescription history from whatever source for the purpose of my continuing care and treatment.

Signature of Patient/Legal Guardian/Representative	Relationship	Date

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____
Last First MI Maiden

Date of Birth _____ Social Security Number _____

I Authorize and Request: _____

_____

_____

_____ _____
Office Phone Office Fax

To Release to: Dr. Chris R. Reeves
14825 N Outer 40 Road, Suite 200
Chesterfield, MO 63017
Office Phone: 314-336-2555
Office Fax: 833-365-7948

Medical Records covering the periods of health care from _____ to _____
Date Date

Please check, and initial, the types of records you do not want released.

☐ HIV Testing/Treatment Records ☐ Substance Use/Abuse History ☐ Psychiatric Evaluation

☐ Other (please specify) _____

The Medical Information is neededfor: _____

ATTENTION: Once this information has been released pursuant to the Authorization, it may no longer be protected by Federal, and/or State law/regulations and may no longer be deemed "confidential."

I understand that neither Dr. Chris R. Reeves or any of its affiliated healthcare providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization, if so requested.

I understand that I may revoke the Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will expire one (1) year from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax, or bring a letter in person stating that I want to cancel this Authorization. I understand that I need to mail, fax or bring the letter to the address or fax number at the top of the page.

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's Death Certificate.

_____ _____ _____
Signature of Patient (if the patient is incompetent, of his guardian or other) *Relationship* *Date*

_____
Printed name of person authorized under State Law to act in the patient's behalf, if the patient is deceased, or his personal representative or if none, of his child, parent, or sibling.

THE ORTHOPEDIC CENTER OF ST. LOUIS
COMMUNICATION AUTHORIZATION

Patient Name _____
Last First MI Maiden

Date of Birth _____ Social Security Number-Last 4Digits _____

I authorize the providers and staff of The Orthopedic Center of St. Louis to discuss and disclose my Protected Health Information (PHI) to the person(s) named below.

Name	Relationship	Phone Number

I authorize the providers and staff of The Orthopedic Center of St. Louis to leave messages:

☐ _____ On my home answering machine / voice mail. _____
Initials Phone Number

☐ _____ On my cell phone voice mail. _____
Initials Phone Number

HIPAA: NOTICE OF PRIVACY PRACTICES

I have received, and/or been provided the opportunity to receive, a copy of the "Notice of Privacy Practices" that explains when, where and why my confidential health information may be used or shared.

I acknowledge that The Orthopedic Center of St. Louis physicians, medical assistants and other staff may use and share my confidential health information with others in order to 1) treat me, 2) to arrange for payment of my bill, and 3) for issues that concern The Orthopedic Center of St. Louis operations and responsibilities.

This authorization remains in force until revoked in writing. The purpose of this disclosure/use is for continued medical care.

_____ _____ _____
Signature of Patient, Guardian, Personal Representative Relationship Date

_____
Print name of person authorized under state law to act in the patient's behalf, if the patient is deceased, or his personal representative, or if none, of his child, parent or sibling.

PATIENT FINANCIAL AGREEMENT

We strive to maintain a strong physician-patient relationship. Sharing our Financial Policy in advance allows for a good flow of communication and enables us to achieve our goal. If you have any questions, do not hesitate to ask a member of our staff.

Health Insurance

- Deductibles, copayment and co-insurance payments are your responsibility.
- We file claims with our contracted insurance plans only. Since the insurance contract is an agreement between you and your insurance company. It is your responsibility to understand your insurance plan benefits with regard to a covered service, if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure. If you have more than one insurance policy, it is your responsibility to inform the office which policy is Primary (first) coverage and which policy is secondary or Tertiary. With each policy, we require the name, birth date, address, phone number, and social security number of the individual who carries the policy.

We expect our patients to pay at time of service any copayment, co-insurance, or deductible required by the insurance company. Because this is an insurance requirement, we cannot bill the patient for these amounts.

Patient/ResponsiblePartyInitial _____

I agree to provide a copy of my insurance card(s) at each visit with the name, address, phone number, date of birth and social security number of the individual who carries the insurance.

Patient/ResponsiblePartyInitial _____

I agree to provide a valid authorization/referral. I understand that if I do not have a valid referral, the staff may ask me to reschedule or pay for the visit in full at check in.

Patient/ResponsiblePartyInitial _____

General Financial Information

Returned Checks: We charge a $30.00 fee for any check returned by the bank. We expect payment by cash, credit card, or money order within 14 days of the notice that your check was returned.

Patient/ResponsiblePartyInitial _____

Past Due Balances: We offer monthly payment plans tailored to each individual's circumstances. If your account becomes delinquent, we reserve the right to take all steps necessary to collect this debt, including referral of your account to a collection agency and/or collection attorney. If such action becomes necessary, you assume responsibility for any and all related fees.

Patient/ResponsiblePartyInitial _____

Workers' Compensation: If your employer has pre-approved treatment, we will file claims and you should not expect to have any financial liability. If your employer has not approved treatment and you choose to receive care by our physician, you assume full financial responsibility for costs associated with that treatment.

Patient/ResponsiblePartyInitial _____

Personal Injury: If you are receiving treatment as part of a personal injury claim or lawsuit, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your personal health insurance, if available. We will require you to sign a Notice of Doctor's Lien. In the absence of insurance, other financial arrangements may be available. Payment of all charges remains the patient's responsibility. We cannot bill your attorney for charges incurred due to your personal injury.

Patient/ResponsiblePartyInitial _____

By signing initialing and signing this form, I agree to all of the terms and conditions herein and the agreement will be in full force and effect. I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Signature of Patient / Guardian / Legal Representative	Relationship to Patient	Date

THE ORTHOPEDIC CENTER OF ST. LOUIS
14825 North Outer Forty Road, Suite 200
Chesterfield, Missouri 63017

PATIENT STATEMENT OF RESPONSIBILITY
PLEASE READ CAREFULLY BEFORE SIGNING

PATIENTNAME _____ Date of Birth _____

- **I acknowledge that Dr. Chris R. Reeves is in contract with United Health Care, Anthem Blue Cross Blue Shield, Cigna Open Access Plus, UMR, and Healthlink. TOC continues to negotiate with insurance carriers for appropriate reimbursement for services rendered. I understand that if I do not have UHC, UMR, Cigna Open Access Plus, BCBS, or Healthlink Insurance , I am using my out-of-network benefits for services rendered at this facility.**
- **I acknowledge that TOC will submit their bill directly to my insurance carrier for services provided by their office. My insurance company may send payment to me directly instead of sending the payment to TOC. In the event I receive a payment from my health insurance company for services rendered by TOC, I will endorse the back of the check and remit payment promptly to TOC, thereby keeping my account in current status.**
- **I acknowledge that any discounts negotiated with me by TOC will become null and void if I cash checks I receive from my insurance company for services rendered by TOC.**
- **I also acknowledge I may contact Merilee at 314-336-2555 ext. 209 with questions regarding my account.**

_____ _____ _____
Signature of Patient, Guardian, Personal Representative | Relationship | Date

_____
Print name of person authorized under State law to act in the patient's behalf
If the patient is deceased, or his personal representative, or if none, of his child parent or sibling.

THE ORTHOPEDIC CENTER OF ST. LOUIS
14825 North Outer Forty Road
Chesterfield, Missouri 63017

PATIENT STATEMENT OF RESPONSIBILITY
MEDICAID INSURANCE COVERAGE

PATIENTNAME_____ Date of Birth _____

PLEASE READ THIS DOCUMENT CAREFULLY BEFORE SIGNING

My name is _____.

- I am completing this form to confirm my full knowledge that The Orthopedic Center of St. Louis is not a contracted provider for the *Medicaid insurance plan*. This means that The Orthopedic Center of St. Louis, cannot, by law, bill Medicaid, and that I accept personal responsibility for any charges incurred in relation to the medical treatment I receive from this entity.

- I understand I will be financially responsible for services provided from this date forward.

- In the event that the entity, The Orthopedic Center of St. Louis, must take legal action to pursue payment from me, I understand that I will bear financial responsibility for any cost(s) incurred by The Orthopedic Center of St. Louis to recoup payment owed.

- I understand that I have informed The Orthopedic Center of St. Louis I am seeking medical treatment because of the effects of an accident in which I was recently involved, and that the matter is currently in litigation. I understand that The Orthopedic Center of St. Louis is willing to forego any collection attempts and is willing to place my account on hold until this litigation matter settles, prior to proceeding with any collection attempts.

- I understand that regardless of the outcome of this litigation matter, I am fully and personally responsible for all charges accrued on my behalf.

- I understand that if I have any questions, I may contact Merilee at 314-336-2555 ext. 209.

_____ _____
Signature, Patient or Legal Guardian Date

_____
Printed Name, Patient or Legal Guardian

THE ORTHOPEDIC CENTER OF ST. LOUIS
MEDICARE PRIVATE CONTRACT

This Contract is entered into by and between ***Chris R Reeves, DO*** *("Physician") whose principal medical office is located at 14825 North Outer Forty Road, Chesterfield, Missouri 63017 and* _____ *("Medicare Beneficiary"), who resides at*

_____

and shall become effective on this _____ *day of* _____, *20* _____ *and shall expire on the* _____ *day of* _____, *20* _____ *(the "Opt-Out Period"), unless otherwise renewed in accordance with 42 U.S.C. § 139a; 45 C.F.R. §, Subpart D.*

- I, Physician, have not been excluded from Medicare under Sections 1128, 1156 or 1892 of the Social Security Act.
- I, the Medicare Beneficiary, or my legal representative, accept(s) full responsibility for payment of charges for all services furnished by Physician.
- I, the Medicare Beneficiary, or my legal representative, understand(s) that Medicare limits do not apply to what the Physician may charge for items or services furnished by the Physician.
- I, the Medicare Beneficiary, or my legal representative, agree(s) to not submit a claim to Medicare or to ask the Physician to submit a claim to Medicare.
- I, the Medicare Beneficiary, or my legal representative, understand(s) that Medicare will not pay for any items or services furnished by Physician that would have otherwise been covered by Medicare if there was no Private Contract and a proper Medicare claim had been submitted.
- I, the Medicare Beneficiary, or my legal representative, enter(s) into this Contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician/physicians who have not opted-out of Medicare, and that I am not compelled to enter into Private Contracts that apply to other Medicare-covered services furnished by other physicians who have opted-out.
- I, the Medicare Beneficiary, or my legal representative, understand(s) that Medigap plans do not, and that other supplemental plans may not elect to, make payments for items and services not paid for by Medicare.
- I, the Medicare Beneficiary, or my legal representative, understand(s) that this Contract cannot be entered into during a time when I, the Medicare Beneficiary, require emergency care services or urgent care services. (However, a physician and/or practitioner may furnish emergency or urgent care services to a Medicare Beneficiary in accordance with Chapter 15 § 40.28 of the Medicare Benefit Policy Manual (2003); 42 C.F.R. § 405.440.
- I, the Medicare Beneficiary, or my legal representative, understand(s) will receive, or have received, a copy (a photocopy is permissible) of this Contract before items or services are furnished under the terms of this Contract.
- Medicare Beneficiary will retain the original Contract (original signatures of both parties required) for the duration of the Opt-Out Period.
- Medicare Beneficiary will supply a copy of the Contract to CMS upon request.
- Medicare Beneficiary understands that this Contract remains in effect for two (2) years. If Medicare Beneficiary again opts-out of Medicare, Medicare Beneficiary will expediently complete a new Contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

PHYSICIAN / PHYSICIAN'S REPRESENTATIVE	**MEDICARE BENEFICIARY/LEGAL REPRESENTATIVE**
Signature	Signature
Printed Name	Printed Name
Date	Date