



SOUTHWEST Spine & Sports

Physicians

Michael W. Wolff, MD*
Jonathan C. Komar, MD*
Anthony A. Lee, MD*
Jason R. Sherman, MD*
Lata Kumaraswamy, DO
John C. Jones, MD

*Board-Certified: Physical Medicine & Rehabilitation
Pain Management

Physician Assistants

Gretchen L. Post, PA-C**
Ashley E. Stowers, PA-C**
Lindsay H. Baumhefner, PA-C**

**Certified: Physician Assistant

Nonsurgical Solutions for:

- Sports Injuries
- Back & Neck Pain
- Herniated Discs
- Joint Pain
- Arthritis
- Nerve Injuries
- Industrial/Work Injuries
- Carpal Tunnel Syndrome
- Acute Injuries
- Muscle & Ligament Sprains & Strains

Leading-Edge Diagnostics & Treatments:

- EMG Testing/Nerve Studies
- Fluoroscopically Guided Injections
- IDET
- Radiofrequency Ablation
- Protein Rich Plasma Therapy (PRP)
- Epidurals
- Percutaneous Disc Decompression
- Provocation Discography
- Medical Acupuncture
- Botox®
- Medical Imaging
- Musculoskeletal Ultrasound

For Your Comfort & Convenience:

- State-of-the-Art Facilities
- Most Insurance Accepted
- Workers' Comp. Welcome
- Multiple Locations

Offices:

9913 N. 95th Street
Scottsdale, AZ 85258

1025 E. Broadway Road, Suite 201
Tempe, AZ 85282

18275 N. 59th Avenue, Suite F132
Glendale, AZ 85308

480-860-8998
480-377-9245 fax
www.swspineandsports.com

Dear

Welcome to Southwest Spine and Sports. We kindly ask that you have this paperwork with you and completed, including signatures where indicated, when you arrive for your appointment.

In the event that you are unable to keep your scheduled appointment, we are happy to reschedule for you; however, there may be a fee. For more information, please refer to our financial policy.

To protect you from healthcare identity theft, in compliance with the FTC's "Red Flag Rule" effective November 1, 2009, we require that you bring a proof of residence with you to your first visit, which we may keep on file. Acceptable forms of proof of residence include utility bills or other correspondence showing current residence. If you, the patient, are a minor, your parent or guardian should bring the information. Please expect to reschedule your appointment if you do not have this information with you at your first visit or for any visits after a change in address.

We look forward to providing you with the highest quality medical care and we hope your visit will be a pleasant one. Please feel free to contact us should you have any questions or if we can be of any assistance, at **(480) 860-8998**. You may also browse our website for directions (also below), forms, educational videos, testimonials, and general information at **www.swspineandsports.com**.

Scottsdale Office

9913 N. 95th St. From the 101 freeway, exit at Shea Blvd. and proceed east to 96th St. At 96th St. turn right (south) and proceed to Ironwood Square Drive. Turn west (right) on Ironwood Square Drive and take first left (south), onto 95th Way, into office complex. We are the fourth building on the left side.

Tempe Office

1025 E. Broadway Rd., Suite 201. The two story tan building is on the second floor of the "Physiotherapy" building, located on the south side of Broadway, just east of Rural. Travelling east- make 1st right after Rural into parking lot. Travelling west- turn left at light on Terrace, make 1st right into parking lot behind building, go around to the side for entrance.

Glendale Office

18275 N 59th Avenue, Suite F132. From the 101 freeway, take the 59th Avenue exit South. We are located South of Union Hills and East of 59th Avenue in Arrowhead Commons.

Reminders

Your Appointment

Day:
Date:
Arrival Time:
Appt Time:
Location:

What to Bring

This packet, completed with signatures/initials
Insurance Card(s)
Copy of utility bill or other proof of residence
Payment or Copayment for specialist office visit
Medical Records pertaining to reason for visit, if applicable



S O U T H W E S T
Spine & Sports

Medical History

Name: _____ Date: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Do you have any allergies to food: Yes No

If Yes, which food: _____

Do you have any allergies to medication: Yes No

If yes, which medication: _____

Are you taking blood thinners? Yes No

If yes, which one: _____

Are you taking anti-inflammatory medications? Yes No

If yes, which one: _____

List any medications you are taking not listed above: _____

List any surgeries that you have had: _____

Do you have any metal in your body? Yes No If Yes, specify where: _____

History of Cancer: Yes No

Are you Claustrophobic: Yes No



S O U T H W E S T
Spine & Sports

AUTHORIZATION TO RELEASE RECORDS

Patient: _____ Social Security #: _____

Phone: _____ DOB: _____

To: _____

Phone: _____

Fax: _____

I hereby authorize and request the release of

ALL medical records and correspondence in my file.

The following records only _____

Please Send Records To:

Southwest Spine & Sports, P.C.

9913 N. 95th St.

Scottsdale, AZ 85258

Phone: (480) 860-8998 Fax: (480) 377-9245

Patient Signature

Date

Witness Signature

Date



S O U T H W E S T
Spine & Sports

Notice To Patients

State law, A.R.S. §32-1401 (26)(ff), requires that a physician notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. I support this law, because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised that I have a direct financial interest in the diagnostic or treatment agency named below:

North Scottsdale Ambulatory Surgery Center

9439 E Ironwood Square Drive, Ste 100
Scottsdale, AZ 85258

Gateway Surgery Center

690 N Cofco Center Court, Ste 150
Phoenix, AZ 85008

Further, all goods or services that I have prescribed are available elsewhere on a competitive basis.

The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. I will keep the signed original in your patient file and you will receive a copy.

ACKNOWLEDGEMENT: I HAVE READ THIS NOTICE AND UNDERSTAND THE DISCLOSURES THAT IT CONTAINS.

Signature of Patient or Guardian

Date



S O U T H W E S T
Spine & Sports

Acknowledgment of Receipt of Privacy Notice

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Patient or legally authorized individual signature.

Date

Printed Name if signed on behalf of the patient

Relationship to patient



Southwest Spine & Sports, PC Financial & Office Policies

Patient Name: _____ DOB: _____

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Payment Policy:

Payment is expected at time of service. Your copay, coinsurance, and/or deductible is due at time of visit. For your convenience, we accept checks, Visa, or MasterCard as a form of payment. Please note that the surgery centers charge additional and separate fees for any procedures at their offices. You will be responsible for payment of any remaining balances from both entities after insurance is billed.

Insurance Policy:

As one of your insurance companies' network providers we require your copayment in advance of your appointment. We also will require a digital scan of your insurance card. We will bill your insurance company. Any deductible, coinsurance or non-covered services will be your responsibility.

For those plans that are non-contracted with our office, as a courtesy, we will submit claims to your carrier; any deductible, coinsurance or non-covered services will be your responsibility.

Monthly statements will be sent to collect those balances. Please inform our staff immediately of any insurance changes.

Non-Covered Service Policy:

Certain services performed by our office are NOT COVERED by all insurance plans. Some of these services include acupuncture, Durable Medical Equipment (DME), Urine Drug Screens (UDS) and certain injections. We suggest you contact your insurance carrier to verify your benefits and understand any non-covered services will be your financial responsibility and payment will be required prior to your appointment. Medicare requires a signature on an Advanced Beneficiary Notice [ABN] for non-covered services.

Delinquent Accounts Policy:

Delinquent accounts may be reported to our collection agency following normal collection procedures. If an account is reported to our collection agency a collection fee of 25% will be added to any outstanding balance. If a balance is over 61 days late, a 1.5% monthly interest fee will be added to the outstanding balance. Please inform our billing staff if you know your payment will be late in arriving or if payment arrangements are needed.

Late Arrivals:

In order for our physicians to see their patients in a timely manner your help in arriving promptly for your appointment is required. If you are more than 10 minutes late, our office will reschedule your appointment to a new date and time. Tardiness affects your patient care as well as those patients that have a scheduled time after you.

We understand your time is valuable and will do our best to respect it and see you in a timely manner. Please be aware that sometimes certain situations and emergencies can occur and cause your provider to run late. Please be patient in these circumstances.

Medical Records:

Should you request a copy of your medical records, please allow our office 7-10 business days for completion.

Forms Policy:

Should you request our office to complete forms on your behalf for disability, work status, FMLA, etc., there will be a charge of \$25.00 per form. Payment of this charge is expected at time of completion.



S O U T H W E S T
Spine & Sports

Southwest Spine & Sports, PC Financial & Office Policies

Appointment Cancellations/No Shows/Reschedules:

There is a \$25.00 charge for established patients and \$75.00 charge for New Patients, EMG's and procedures who cancel, reschedule or no show for an appointment without giving 48 hours notice, these appointments times could have been given to another patient who needs medical care. We understand unusual circumstances may arise, please contact our office as soon as possible.

Prescriptions:

Appointments are required for medication refills. Please contact our office a minimum of 10 days prior to your scheduled refill date. Phone call refills are not allowed.

Returned Checks:

Our office charges a \$25.00 fee for all account closed, stop payment or non-sufficient funds returned checks.

Referrals & Authorizations:

If a referral is required by your insurance carrier you will be asked to obtain the referral prior to your appointment. If no referral exists on file or your referral has not been received, your appointment may be cancelled. Our office will obtain authorization for your procedure prior to scheduling your appointment. We suggest you contact your insurance carrier to verify your coverage, benefits and preauthorization requirements prior to having any procedures performed. Claims are paid based on medical necessity. Please be aware authorizations and referrals are not a guarantee of payment.

Workman's Compensation:

Our office will require you to inform us of any changes regarding your workers compensation claim. The following information is required: Adjustors Name, claim status, (litigation, supportive care, claim closed, new injury), DOI, carrier, claim number and claims address. Please have this information available prior to your appointment time.

Third Party Billing:

Our office does not accept medical liens or automobile cases. However, we do use a lien company, National Health Finance, who may be willing to handle your lien case. Please contact them at 602-347-8503.

_____ Date _____
(Patient/Guarantor Printed Name)

_____ Date _____
(Patient/Guarantor Signature)

Review by: _____ Date _____

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