

# THE STONE CLINIC

ORTHOPAEDIC SURGERY, SPORTS MEDICINE, AND REHABILITATION

*Welcome to the office of Kevin R. Stone, M.D.*

## PATIENT INFORMATION RECORD

TODAY'S DATE: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Last

First

MI

Address: \_\_\_\_\_

Street

City

State

Zip Code

Home Phone (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cellular (\_\_\_\_) \_\_\_\_\_

(Please circle best number to reach you during the day)

E-Mail Address: \_\_\_\_\_ Sex:  M  F

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Social Security #: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

How did you learn about The Stone Clinic? Doctor / Former Patient / Friend / Internet / Yellow Pages / Other?

Name: \_\_\_\_\_

### Emergency Information

Person to Call: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Payment is required at the time of service. Most insurance companies cover Stone Clinic services as an out-of-network provider. We will assist you in obtaining reimbursement by providing you with an itemized "superbill" receipt, which you can send, as is, to your insurance company for reimbursement. Your signature below indicates you are financially responsible for all charges incurred, that you understand unpaid balances over 60 days will be assessed 1% compounded monthly interest unless other arrangements have been made, and that outstanding balances over 90 days will be processed by a Collection Agency.

Signature of Patient or Legal Guardian: \_\_\_\_\_

### PLEASE CHECK PAYMENT METHOD:

Cash  Check  MasterCard / Visa  American Express

Credit Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Security Code: \_\_\_\_\_

(Shown on reverse side of card in the signature label)

Credit Card Authorization Signature: \_\_\_\_\_

PLEASE PRESENT YOUR INSURANCE CARDS TO THE RECEPTIONIST SO WE MAY HELP YOU WITH YOUR INSURANCE REIMBURSEMENT.

THE STONE CLINIC  
ORTHOPAEDIC SURGERY, SPORTS MEDICINE, AND REHABILITATION  
**GENERAL FINANCIAL POLICY**

Payment in full is required at the time of each visit except for the following situations:

1. **MRI** – An MRI can be performed today if Dr. Stone feels it will aid in diagnosing your injury. If you choose to proceed with this procedure:

**50%** payment of fee is due at the time of service.  
**25%** is due **30 days** from the date of service.  
The remaining **25%** is due **60 days** from the date of service.

2. **CUSTOM KNEE BRACE** – An appointment will be made for a custom knee brace fitting if Dr. Stone feels it will aid in your particular situation. If you choose to proceed with this procedure:

**50%** payment of cost of brace is due at the time of fitting.  
**25%** is due **30 days** from the date of service.  
The remaining **25%** is due **60 days** from the date of service.

3. **SURGERY** – If Dr. Stone recommends surgery:

**50%** payment of the Total Estimated Cost is required before surgery is scheduled.  
**25%** payment of surgical fees is due **30 days** from the date of service.  
The remaining **25%** is due **60 days** from the date of service.

The Stone Clinic will prepare a complete packet of information for you to send, as is, to your insurance company so that you can obtain the best reimbursement possible as soon as possible.

X-rays, MRI, exercise instruction by the Physical Therapy Department and supplies will incur a separate charge from the physician's fee.

The Stone Clinic offers a number of payment options for your consideration including MasterCard, VISA, American Express and Care Credit, a 0% interest-free independent payment program. Your signature below indicates you are financially responsible for all charges incurred, that you understand unpaid balances over 60 days will be assessed 1% compounded monthly interest unless other arrangements have been made, and that outstanding balances over 90 days will be processed by a Collection Agency.

We will do everything possible to assist you in obtaining reimbursement from you insurance company. An itemized "superbill" will be given to you after each visit with codes and information regarding your visit that you may mail directly to your insurance carrier for reimbursement directly to you. If you bring your insurance information with you to The Stone Clinic, you can mail in the reimbursement request from this office. We will be happy to assist you with pre-authorizations and provide letters of medical necessity or operative reports for your billing needs.

I acknowledge having read and understand the above General Financial Policy.

I authorize The Stone Clinic to release any information required to process my claim.

\_\_\_\_\_

Print Patient Name

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Patient or Legal Guardian

Is the address listed on the previous page your billing address? \_\_\_\_\_  
If not, please note billing address: \_\_\_\_\_