Tooele Orthopaedics &
Sports Medicine Specialists, PC
Dr. John Douglas

2356 N. 400 E., Ste: 102
Tooele, Utah 84074
435-833-9180

Patient Bill of Rights

As a patient of Tooele Orthopedics & Sports Medicine Specialists, PC you have the right to considerate and respectful treatment from all staff members of the Clinic.

- You have the right to information you can understand on your condition, treatment and progress.
- You have the right to refuse treatment to the extent permitted by law, and the right to be informed of the alternatives and consequences of refusing treatment.
- You have the right to expect reasonable confidentiality of all records and communication about your medical care.
- You have the right to request a copy of your medical records.
- You have the right to request an explanation of your bill.
- You have the right to know if your physicians wish to include clinical research (such as the use of a new drug) as a part of your care, and you have the right to refuse to participate in such research.

If you have a compliment, suggestion, or complaint, please let us know.

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Mission Statement

At Tooele Orthopedics & Sports Medicine Specialists, PC we put special emphasis on your personal care. We listen to you and pay attention to your individual needs, offering both specialized and comprehensive medical care.

Our mission is to provide the finest professional medical care in a comfortable, caring and state-of-the-art environment. We are committed to promoting wellness through education and preventive medicine.

Excellence, Compassion, Commitment

TOOELE ORTHOPAEDICS

Dr. John Douglas
Scott Bruderer, PA-C
Craig Packham, PA-C

Today's Date:

PCP:

Email:

PATIENT INFORMATION

Patient's last name: First: Middle: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No If not, what is your legal name? (Former name): Birth date: Age: Sex: ☐ M ☐ F

Street address: Social Security: Home phone: ( ) Cell phone: ( )

P.O. box: City: State: ZIP Code:

Occupation: Employer: Employer phone: ( )

Chose clinic because/referred to clinic by (Please check one box): ☐ Dr. ☐ Insurance plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: Address (if different): Home phone: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation: Employer: Employer address: Employer phone: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ [Medicare] ☐ [BCBS] ☐ [SelectHealth] ☐ [UHC] ☐ [Cigna] ☐ [Altius] ☐ [Tricare] ☐ [PEHP] ☐ Worker's Comp ☐ Other

Subscriber's name: Subscriber's S.S. no.: Birth date: Group no.: Policy no.: Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): Subscriber's name & Birth date: Group no.: Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I have been given a copy of and agree with the financial policy and I am financially responsible for any balance. I also authorize Tooele Orthopaedics or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Anti-Kickback Law

Dear Patient:

Due to policy provisions in your contract with your insurance carrier, we are obligated to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, co-insurances, or co-payments, please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.

If we are networked with you carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier. If a portion of your fees are applied to an annual out of pocket maximum, and we do not collect that fee, your out of pocket maximum has not been correctly calculated.

Additionally, for those Medicare patients that may have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility co-insurance, co-payment, or deductible under the terms of the anti-kickback laws.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we must be bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance, we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Sincerely,

John A. Douglas, DO

Print Patient Name: _____

Patient (Parent/Guardian) Signature: _____

Date: _____