REGENERATIVE
SPINE & JOINT CENTER

BORIS TEREBUH, MD
www.RegenerativeSpineAndJoint.com
6860 Perimeter Drive, Suite A
Dublin, Ohio 43016
(614) 389-3089, (614) 389-3876 fax

Office Policies and Procedures

Patient Name (print): _____

*Please read and initial our office policies below and return **All** paperwork, your photo ID, Insurance card, and co-pay at your initial visit.*

*_____ (initial) I understand that Regenerative Spine & Joint Center (RSJC), Dr. Boris Terebuh, will bill my insurance company for covered benefits if I present my insurance card at the time of service. I understand I am financially responsible for services that are not covered or that are deemed patient responsibility by my insurance company within 30 days of receiving a statement unless arrangements have been made prior. I understand I am financially responsible for any amounts applied to my deductible payable within 30 days of receiving a statement unless arrangements have been made prior. I understand I am responsible for resolving any disputes with my insurance company regarding payment of services.

*_____ (initial) I understand I am responsible for paying my co-pay at time of service. RSJC reserves the right to reschedule an appointment if co-pay is not paid at time of service.

*_____ (initial) I understand I am responsible for providing my insurance card and photo ID at the time of service. RSJC reserves the right to reschedule an appointment if Insurance card and photo ID are not presented at New Patient Appointments or when an insurance has changed.

*_____ (initial) I understand I am responsible to pay $25.00 for *first set* of paperwork presented for FMLA, Disability, etc. and $50.00 for each from filled out thereafter. I understand that it can take up to 10 business days for paperwork to be completed. I understand is my responsibility to pick up paperwork during normal business hours. I understand RSJC does not fax or mail paperwork to a third party.

*_____ (initial) I understand I am responsible for paying any medical record copying fee allowable by law.

*_____ (initial) I understand it is my responsibility to make sure Dr. Boris Terebuh is in my insurance network.

*_____ (initial) I understand I am responsible for arriving on time to every appointment and RSJC reserves the right to reschedule my appointment if I am late.

*_____ (initial) I understand I am responsible to provide any changes in my phone number, address or insurance at every appointment.

*_____ (initial) I understand it is my responsibility to provide / bring copies of medical records from any other physicians I have seen for this problem.

*_____ (initial) I understand it is the mission of RSJC to maximize the function and independence of our patients. Philosophically, the prescription of opioids is minimized in our treatment plans and when appropriate, we recommend the discontinuation of opioid prescriptions all together. RSJC does not prescribe opioid prescriptions to maintain chronic pain symptoms.

Office Policies - continued

*_____ (initial) I understand I am responsible to give a 48 hour notice to RSJC if I need to cancel or reschedule an appointment. It is the standard practice of our office to call our patients at least 48 hours before a scheduled appointment to remind them of the appointment date and time. If you are unable to keep your scheduled appointment, our expectation is for **you, the patient,** to notify our office as soon as possible to reschedule or cancel. **A minimum of 24 hours notice is expected,** which allows our office time to offer the appointment slot to someone else in need of our care. By initialing this paragraph and by signing below, you understand that if you fail to notify us within the 24 hour time frame or are a No Call No Show for your appointment, a rescheduling fee in the following amounts will be required before any future appointment can be made:

Follow up Appointment- $50
New Patient Appointment- $100
Injection / Procedure or EMG- $150.00

We do understand circumstances may arise that prevent advance notice and those are taken into consideration.

*_____ (initial) I give my consent to RSJC and Dr. Boris Terebuh to administer diagnostic and therapeutic treatment of my condition and/or injuries and to perform minor procedures, as deemed necessary, by Dr. Boris Terebuh. I consent to physical examination as necessary to diagnose and treat my condition. I consent to medication reconciliation from outside prescribers for the purpose of treating my condition.

I understand that by signing below I agree to the above policies and procedures.

Patient Name (Print)

Patient Signature (or Representative and Relationship to patient)

Date Signed