orthopedic ONE

Account # _____ **Dr #** _____

Patient Name: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: ☐ M ☐ S ☐ D ☐ W Sex: ☐ M ☐ F DOB: _____ Age: ____ Social Security: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: _____

May we leave a voice mail: ☐ Y ☐ N May we speak with another resident: ☐ Y ☐ N

Primary Doctor: _____

Referring Doctor: _____

If no referring doctor, how did you hear about Orthopedic ONE?

☐ Internet ☐ Yellow Pages ☐ Existing Patient ☐ Insurance ☐ Friend/Family ☐ Other _____

Is your injury work-related: ☐ Y ☐ N If yes, date of injury: _____

Claim number: _____ MCO: _____

PRIMARY INSURER

Responsible Party for Insurance & Bills: ☐ Self ☐ Spouse ☐ Parents ☐ Mother ☐ Father ☐ Other _____

Insurance Company: _____

Name of Insured: _____

DOB of Insured: _____ SS# of Guarantor: _____

Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Dependent

SECONDARY INSURER (If Applicable)

Responsible Party for Insurance & Bills: ☐ Self ☐ Spouse ☐ Parents ☐ Mother ☐ Father ☐ Other _____

Insurance Company: _____

Name of Insured: _____

DOB of Insured: _____ SS# of Guarantor: _____

Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Dependent

Preferred Pharmacy Name: _____

Pharmacy Location (street name & city): _____

Mail Order Pharmacy Name: _____

Mail Order Pharmacy Phone Number: _____

I understand and request that payment of authorized insurance company benefits be made directly to Orthopedic ONE on my behalf for all rendered services. I authorize any holder of medical information about me to release information needed to determine these benefits or the benefits payable to related services. I am responsible for any co-pay, co-insurance, deductible and non-covered amounts. I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided. ☐ Yes ☐ No

**** Signature:** _____ **Date:** _____

Orthopedic ONE

CONSENT TO THE USE/DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights and responsibilities with respect to your health care information.

The Notice of Privacy Practices provides more detailed information about how Orthopedic ONE may use and disclose health information. I have the legal right to review the Notice of Privacy Practices before I sign this consent, and Orthopedic ONE encourages reading it in full. My signature below verifies that I have received the Notice of Privacy Practices. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing. I have the right to request how my health information is used and disclosed. I also have the right to restrict how this information is disclosed, but the practice is not legally required to agree to these restrictions. Orthopedic ONE must receive requests for any restriction of disclosure in writing.

I hereby authorize Orthopedic ONE to release any information acquired in the course of my examination or treatment for the purposes of treatment, payment and healthcare operations. This information may be delivered in person, via regular mail, modem, telephone, or facsimile transmission. The information may be viewed by someone other than the intended recipient and I hereby release Orthopedic ONE from any liability as a result of such transmission.

I have been informed and understand that Orthopedic ONE will not bill third party payors (automobile/homeowners or other business insurances). I understand that all charges accrued by me must be submitted to my private health insurance, and third party payors must settle privately with these individuals. I further understand that any unpaid balance is my financial responsibility.

I understand that I may revoke this consent in writing, but the revocation will not apply to any services given before the revocation was signed. I also understand that by refusing to sign this consent or revoking this consent, this practice may refuse all services.

CHECK ONE:

☐ I authorize payment of surgical and/or medical benefits directly to Orthopedic ONE. I understand I am financially responsible for all charges not covered and guarantee payment of this account

OR

☐ For the following reasons, I agree to be responsible for all bills incurred in the course of my examination and treatment

- ☐ No insurance coverage in force at this time.
- ☐ I do not wish to have Orthopedic ONE bill my insurance company for me.

AUTHORIZATION TO DOWNLOAD MEDICATION HISTORY

By signing below, I am giving Orthopedic ONE my consent to retrieve and use my medication history from SureScripts

_____	_____
Patient Name	Date of Birth
_____	_____
Signature of Patient or Responsible Party	Date

Orthopedic ONE

PATIENT FINANCIAL POLICY

We are committed to provide you with the best possible orthopedic care, and will work with you to meet any special needs you might have. However, that requires that both the patient and physician understand what is expected of the other, medically and financially.

The following information is an agreement between Orthopedic ONE and Patient/Responsible Party named below. By signing this agreement, you are acknowledging that you understand our insurance and financial policies and are agreeing to pay for all services that are received.

Insurance Participation

Our office participates in a variety of insurance plans, and we will submit all claims to those carriers. However, there are several points we wish to emphasize:

- Your policy is a contract between you and the insurance company. While we will assist as much as possible, it is your responsibility to be familiar with your coverage and contact them directly if you have questions.
- You must bring your insurance card with you to every visit, and make us aware of any changes in coverage.
- You are expected to pay your copayment at each visit. If you ask us to bill you for this amount, or decline to pay on the date of service, there will be a $10.00 processing charge added to your account.
- If we do not participate with your insurance, you will likely have a higher out-of-pocket expense, so please be prepared.

Self-Pay Patients

If you do not have insurance, you will be asked to pay your balance at the time of your visit. Should you schedule elective surgery, we require that 50% of the estimated fees be paid at least one week prior to surgery, or the surgery will likely be canceled.

Payment Arrangements

If you need to arrange a payment plan, please ask for someone to assist you while you are in the office. Based upon your total balance, we may offer limited payment terms.

No-Show Charge

If you are unable to keep your appointment, and do not provide at least 24 hours notice of cancellation, you may be subject to a$25 charge.

Minors

If the patient is under age 18, the parent or guardian must sign below. If the minor does not reside with both parents, and there is a dispute over which parent is responsible for any bills, we will ultimately rely upon the parent/guardian who brought the child to the office for financial responsibility.

Past Due Accounts

If your balance is not paid in a timely manner, we reserve the right to forward your account to an outside collection agency or attorney. All fees assessed by the agency or attorney will be charged to you and become part of your outstanding balance.

I HAVE READ, UNDERSTAND AND AGREE TO COMPLY WITH THESE POLICIES.

Date: _____ Name: _____
Print Name of Patient

Signature: _____
Signature of Patient or Responsible Party