Medical Office

- PATIENT INFORMATION & HISTORY FORM

Patient Name _____ ☐ Male ☐ Female
LAST FIRST MIDDLE

Patient's Date of Birth ____/____/____ Age _____ Patient's Social Security # ____/____/____
Month Day Year

Home Address _____ Apt # _____ Lot # _____ _____
Street City State Zip

Mailing Address _____ _____
City State Zip

Is this address: ☐ permanent ☐ temporary (check one) Patient's Marital Status ☐Single ☐Widowed ☐Divorced ☐Marrie

Home Phone (_____)_____ Work Phone(_____)_____ Cell Phone (_____)_____

E-Mail address _____

If Patient Lives in a Nursing Home or Assisted Living Facility, please provide Name of Facility_____
Address_____ Phone _____

EMERGENCY INFORMATION

EMERGENCY CONTACT NAME _____ RELATIONSHIP TO PATIENT _____ Phone _____

NEAREST FRIEND NOT LIVING WITH YOU _____ Phone _____

MEDICARE/MEDICAID

MEDICARE NO:_____

EFFECTIVE DATE ____/____/____

MEDICAID NO: _____

DATE OF MONTH ELIGIBLE _____ STATE ISSUED _____

PRIMARY Insurance Information

Name of Insurance Company _____
Address of Insurance Co _____
Policy # _____ Group # _____
SUBSCRIBER'S NAME_____ (as on insurance card)
Relationship to Patient : ☐ Self ☐ Spouse ☐ Child ☐ Other _____
SUBSCRIBER'S ADDRESS _____
CITY, STATE _____, _____ ZIP _____
PHONE _____
DATE OF BIRTH ____/____/____ SEX ☐ Male ☐ Female
Social Security # of Insured ____/____/____

SECONDARY Insurance Information

Name of Insurance Company _____
Address of Insurance Co _____
Policy # _____ Group # _____
SUBSCRIBER'S NAME_____ (as on insurance ca
Relationship to Patient : ☐ Self ☐ Spouse ☐ Child ☐ Other _____
SUBSCRIBER'S ADDRESS _____
CITY, STATE _____, _____ ZIP _____
PHONE _____
DATE OF BIRTH ____/____/____ SEX ☐ Male ☐ Female
Social Security # of Insured ____/____/____

SPOUSE OR GUARDIAN INFORMATION

Name _____
SSN _____ DOB ____/____/____
Address of Spouse or Guardian _____ City _____ State_____ Zip _____
Spouse or Guardian's Employer _____
Employer's Address _____ City _____State _____ Phone _____
If Patient is under 18 years of age, please state your relationship to the patient: _____

WHO IS YOUR FAMILY PHYSICIAN? _____ WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

WHAT IS YOUR OCCUPATION? _____ NAME OF PATIENT'S EMPLOYER_____
EMPLOYER'S ADDRESS _____
CITY, STATE _____ EMPLOYER'S PHONE _____

PAYMENT POLICY

The doctors and staff of [redacted] are committed to providing our patients with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this, we need your assistance and understanding of our payment policy.

All services are provided for a fee for service basis unless you are associated with a managed care plan. In the case of a managed care plan, you will be required to pay your co-pay only. Payments for office visits, insurance co-payments and deductible are expected when the service is rendered. We accept cash, personal checks or credit cards.

AUTO ACCIDENTS/OTHER ACCIDENTS

When your injuries are the result of an accident and an attorney will be handling your case in court or another party's insurance company is presumed responsible for your charges, the patient is still responsible for payment of the bill. Orthopedic Center cannot be expected to wait for the conclusion of long-term court case or settlement of a disputed insurance claim before being paid. You will be required to make a payment of $250 before being seen and with each visit that follows. You also are responsible for payment of the balance of your bill should charges exceed the $250 you pay at each visit.

WORKER'S COMPENSATION

Patients who are injured on the job should report the injury directly to their employer. The employed will be responsible for directing the employee to a doctor who is listed on their PANEL OF PHYSICIANS. Before we will be able to see you as a patient, we will require you to fax or bring in a letter verifying that your employer will be responsible for your charges. If a patient comes in for a visit **without** this information, we will have to ***reschedule*** the appointment. This information is necessary to avoid the patient being responsible for the bill.

MEDICAID

Please bring a copy of your Medicaid card to each visit; otherwise we will have to bill you directly. You will be responsible for all services not covered by Medicaid. This will include certain supplies and any office visits made after your twelve (12) authorized visits.

INSURANCE

Your insurance coverage is a contract between you and your insurance company. As a courtesy, we will file your office and surgery charges and all Medicare services with your insurance carrier. You may be requested to pro-pay your unmet deductible and co-insurance prior to any surgery performed or following emergency services.

You will continue to receive a statement each month even though your insurance is pending. [redacted] cannot accept the sole responsibility for collecting your claim or negotiating a settlement on a disputed claim since we are not a party to your insurance contract. If you have a question regarding your account or the filing of your insurance, call [redacted] and ask for the Insurance department. We will be happy to assist you.

If you need to set up an extended payment arrangement, contact our Insurance Department. If no payment has been received after 90 days from the date the services were rendered, necessary collection procedures through Equifax will begin.

AUTHORIZATION FOR SERVICES

The signature below serves as authorization for services rendered by [redacted] for the above named jpatient, and release of information for payment of services, treatment, and/or operational purposes; and assign benefits otherwise payable to policy holder to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by the insurance carrier - a copy of the signature is as valid as the original.

AUTHORIZATION FOR RELEASE OF INFORMATION

The signature below serves as authorization for Orthopedic Center to release or receive medical information for the purpose of patient referral. A copy of thsi signature is as vilid as the original.

Date_____ Signature_____

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

I, _____, understand that as part of my healthcare, [redacted] originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that the information serves as:

- a basis for planning my care and treatment,
- a means of communication among the many health professionals who contribute to my care,
- a source of information for applying my diagnosis and surgical information to my bill,
- a means by which a third-part payor can verify that services billed were actually provided and
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- the aright to review the notice prior to signing this consent
- the right to object to the use of my health information for directory purposes, and
- the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that [redacted] is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the code of Federal Regulations.

I further understand that [redacted] reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should [redacted] change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. Mail or if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

_____ _____

Patient's Signature **Date**

FOR OFFICE USE ONLY:

□ consent received by _____ **on** _____

□ consent refused by patient and treatment refused as permitted.

□ consent added to the patient's medical record on _____

PATIENT RECORD OF DISCLOSURES

In general, HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI by made by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner:

(check all that apply):

□ **Work Telephone**
- □ o.k. to leave message with detailed information
- □ leave message with call-back number only

□**Home Telephone**
- □ o.k. to leave message with detailed information
- □ leave message with call-back number only

□**Written Communication**
- □ o.k. to mail to my home address
- □ o.k. to mail to my work/office
- □ o.k. to fax to this telephone number _____

You may leave messages with, discuss my treatment, appointments or other scheduling that may occur or give other information as necessary with the following family, friends or personal representatives. I understand that [redacted] will refuse to discuss my information with anyone not listed below, except in an emergency. I also understand that this consent does not apply to medical providers.

PLEASE PRINT

1. _____
2. _____
3. _____
4. _____
5. _____

Patient's signature _____ **Date**_____

Please print name _____

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of [redacted] Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law.

Signed _____ **Date** _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed by: _____

(FOR ORTHOPEDIC CTR INTERNAL USE)

IIf patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign here:

Presented by _____ *(name & title)*

Date _____ *Time* _____

ACCIDENT DETAILS

PATIENT'S NAME _____ **DATE OF BIRTH** _____/_____/_____

Is your visit today the result of a work-related or auto accident? □ **YES** □**NO**

If YES, which one?: □ **Work-Related** □ **AUTO ACCIDENT**

Signature of patient or guardian _____ Date _____

If YES, please complete the following:

1. **What** happened?
2. **Where** did the accident occur?
3. **When** did the accident occur? (DATE)
4. Is there any other insurance coverage (such as a homeowner's policy, school insurance, worker's compensation, etc.) that will pay this bill? □ YES □ NO

   a. **If YES**, please give us the information in the space provided for that insurance company:

   _____ _____
   NAME OF COMPANY INSURED'S NAME

   _____
   INSURANCE COMPANY ADDRESS

   _____
   CITY, STATE, ZIP

   _____ _____ _____
   PHONE POLICY # CLAIM #

ATTORNEY'S NAME _____ ADDRESS _____ PHONE_____

IF WORK RELATED:
EMPLOYER NAME _____
EMPLOYER ADDRESS _____
WAS INJURY REPORTED TO EMPLOYER? □ YES □ NO
If YES, list the name of the person you spoke with _____ PHONE_____

AUTO ACCIDENT/OTHER ACCIDENT

When your injuries are the result of an accident and an attorney will be handling your case in court or another party's insurance company is presumed responsible for your charges, the patient is still responsible for payment of the bill. [redacted] cannot be expected to wait for the conclusion of long-term court case or settlement of a disputed insurance claim before being paid. **You will be required to make a payment of $250 before being seen and with each visit that follows. You also are responsible for payment of the balance of your bill should charges exceed the $250 you pay at each visit.**

WORKER'S COMPENSATION

Patients who are injured on the job should report the injury directly to their employer. The employer will be responsible for directing the employee to a doctor who is listed on their Panel of Physicians. Before we will be able to see you as a patient, we will require you to fax or bring in a letter verifying that your employer will be responsible for your charges. If a patient comes in for a visit without this information, we will have to reschedule the appointment. This information is necessary to avoid the patient being responsible for the bill.

Signature of patient or guardian _____ Date _____

/ag 3-10-2007

[redacted] PRIVACY PRACTICES

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

At the [redacted] we work hard to protect your privacy. At the same time, we are following some new federal requirements to help protect your privacy.

The new laws give us permission (authorization) to use your medical information for certain uses, but not for others.

Your personal medical information is called Protected Health Information or "PHI".

[redacted] and our medical staff can use your PHI or share it with each other only in certain ways. We must also follow rules about sharing your Protected Health Information outside of our system.

Using Your PHI Without Your Permission

The law allows us to use your PHI without your permission in several different ways. For example:

For your Treatment Any of our medical staff involved in treating you can use your PHI. We can also share it with others involved in your care. Your doctor may share your PHI with another doctor whom he or she consults with about your condition. We can share your information with another covered entity with whom we have an "organized health care arrangement" (OHCA) - for example, a radiologist that sees patients in our surgery center.

For Payment Your PHI can be used and shared to collect payment for services. We are allowed to give your PHI to billing services or other health plans or providers for billing.

For Our Business Operations We may use your PHI to train our staff, manage our budget, check on the quality of care we give. These are a few examples of the many ways we conduct business.

We can share with other doctors and nurses, medical staffs in an effort to help them learn how to do their jobs better.

We can also share your PHI with lawyers who help us follow the law.

We can also share PHI with other health care providers and health plans where you have been a patient in the past.

To Follow The Law We may share PHI to follow the law, to report or solve crimes, or to help law enforcement.

To Protect Public Health We may give your PHI to others who work to prevent the spread of diseases. And we must report abuse and neglect.

To Oversee Health Care Systems We can give PHI to government agencies that inspect health care systems.

To Help Coroners or Medical Examiners We may need to give PHI to help identify a body or the cause of death.

For Organ or Tissue Donation We may give PHI to help agencies who match organ donors with people on waiting lists.

For Research We may use PHI for medical research.

We Can Usually Turn You Down If The Information:

- Wasn't written by us
- Is not part of our records
- Is not something you are allowed to see
- Is not correct and complete

If we turn you down, we will tell you why in writing. We will also explain what other steps you can take, such as:

- Saying in writing that you don't agree with us or
- Asking in writing that we include a copy of your letter and our answer with your PHI from now on; and
- Complaining about being turned down.

You Can Ask That We Fix Mistakes Or Add New Facts To Your PHI

You must ask us in writing. Write to the Privacy Officer at the [redacted]. Please explain why you are asking us to add to or change your PHI.

We will try to get back to you within sixty (60) days after the date of your request. At that time, we will let you know if we agree to make the requested change.We'll also let you know what change we will make, if any.

You Can Ask For A List Of People And Groups Who Have Seen Your PHI In The Past Six (6) Years.

(But we can only give information about what has happened since [redacted])
The list will not include times when you gave your written permission. And it won't include things already covered in this Notice. These include giving out your PHI:
For treatment, payment, and health care operations to you: For lists of patients; People involved in your care; Government functions; Or to law enforcement.

You must ask for the list in writing to Privacy Officer, [redacted]. We will try to get back to you within sixty (60) days after we get your letter. We will give you one list each year at no charge. But we will charge you a fee of $25.00 for each list after that in a single year.

You can ask for a paper copy of this Notice.

Please contact the front desk or the Privacy Officer, P.C. to get another copy of this notice.You can also get a copy of this Notice at our website, www.orthocentersav.com

You may complain to us if you believe your privacy rights have been violated.

Contact the Privacy Compliance Officer at [redacted] Your complaint must be in writing. We will not punish you or do anything against you for complaining.

You also have the right to complain to the Secretary of the Department of Health and Human Services.

If you have any questions about this Notice, please contact the Privacy Compliance Officer at the [redacted], at [redacted]

Effective Date: April 14, 2003