Today's Date: __________

Last Name: ______________________________ **First Name** __________________________________ **MI** _____
Date of Birth __________________ **Age** _____ **Gender** _________ **Marital Status:** _______________________
Race (optional): **Black** **White** **Asian** **Hispanic** **American Indian** **Other**
Address _________________________________ **Apt #** _____**City** ________________ **State** ____ **Zip** ________
Home Phone (_______) ______________ **Cell Phone** (_______) ______________ **Employer** __________________
E-Mail: __________________________@_______________________**Occupation** ___________________________

How did you hear about us? ____

EMERGENCY CONTACT
Name ____ **Relationship** ____________________________
Home Phone (_____)_____________________**Cell Phone** (_____)________________________

Primary Care Doctor
Name __________________________
Phone (_____)___________________

Preferred Pharmacy
Name _____________________________________
Address _____________________________**Phone #** ______________

INSURANCE INFORMATION
Primary Insurance Co Name ____________________________________ **Policy/Member #** ____________________
Policy Holder's Name (if other than self) __________________________________**Date of Birth** ________________
Policy Holder's Relationship to Patient ___________________________

Secondary Insurance Co Name ___________________________________ **Policy/Member #** ____________________
Policy Holder's Name (if other than self) __________________________________**Date of Birth** ________________
Policy Holder's Relationship to Patient ___________________________

WORKERS COMPENSATION INFO
Company Name: ____
Company Address: ____________________________________**City**____________________**State**______**Zip**_______
Date Of Injury: ________________________________ **Case #** ____
Caseworker Name: ____________________________________ **Telephone** (_____) ___________________________

PATIENT REGISTRATION FORM

Patient Registration (continued):

INSURANCE AUTHORIZATION, RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize SpecOrtho to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. It may be used to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested the medical service of **SpecOrtho** on behalf of myself and/or dependents, and I understand by making this request, I become fully financially responsible for any and all charges occurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, Medigap, Medicaid, private insurance and any other health/medical plan to issue payment directly to SpecOrtho for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand I am responsible for any amount not covered by insurance, regardless of insurance coverage. **Initials: ______**

NOTICE OF PRIVACY

I acknowledge that upon request I received a copy of the **SpecOrtho** "Notice of Privacy Practices". I have read and understand all the above and agree to comply. **Initials: ______**

CONSENT TO USE PHOTOS

I authorize SpecOrtho to use my photograph (without names) or that of my child in print publications, online publications, presentations, websites and social media for the publication of the practice. I also understand that no royalty, fee or other compensation shall become payable to me by reason of such use. **Initials**: _______

CONSENT TO TREAT

The purpose of medical care is to facilitate the treatment of disease, injury and disability. Medical services are provided through examination, testing and use of procedures to the aid of diagnosis or treatment of a medical condition. I request and authorize **SpecOrtho** to provide me with medical services as described above. I agree to cooperate fully, to participate in all medical procedures and to comply with the plan of medical care/services that is established.

Initials: ______

RESPONSIBLE PARTY (Adult Present signing consent to treat if the patient is a minor or Power of Attorney is necessary)

Last Name ______________________________________ **First Name** ____

Patient Relationship to Responsible Party __________________________ **Date of Birth** _________________________

Address ______________________________ **Apt** _____**City** _____________________ **State** ______ **Zip** ________

Home Phone (_____) _____________ **Work Phone** (_____)_____________ **Cell Phone** (_____)_________________

Patient Name ____________________________________

SpecOrtho

Specialty Orthopaedics and Sports Medicine, LLC

FINANCIAL POLICY/PATIENT RESPONSIBILITY

Welcome to SpecOrtho and thank you for choosing us as your orthopaedic healthcare provider. We are committed to providing our patients with convenient and personalized care. In addition to the practice of exceptional medicine, we believe a clear understanding of our Financial Policy is essential to our professional relationship. Your commitment to your account is just as significant as your participation with your health care. **Please remember that you, the patient or guardian, are ultimately responsible for all charges associated with your care regardless of insurance coverage**.

Patients with Insurance:

SpecOrtho requires a copy of any insurance information and photo identification at the time of service. We participate with most major health plans and our business office will file claims on your behalf. Should you have an outstanding balance after your insurance posts, we will expect the courtesy of prompt payment.

Please note: We will collect all patient responsibility per your insurance contract at the time of your appointment (copay, deductible, etc). If your patient responsibility cannot be verified, the following charges will apply:

- New Patient Visit - $100.00
- Established Patient Visit and Follow Ups - $50
- On site MRI - $100
- Surgical Procedures- $200 (minor); $400 (complex)

The above amounts are only estimates of our services. You will be provided with a billing statement after your insurance has been applied.

Self-Pay Patients:

At the time of your appointment, we will collect the following amounts based on your services received:

- New Patient/new problem - $150 for first ailment; $50 for each additional issue
- Follow-up visit - $90 for one ailment; $30 for each additional issue
- X–Rays - $50 for each series
- Injections/Aspirations - $50 for each plus cost of medication (if applicable)
- MRI - $600
- In-office procedures to be quoted individually

No-Show Policy:

Please notify us more than 24 hours in advance if you are unable to keep your appointment. Multiple late cancellations/no shows may result in a $50 charge which is not covered by insurance.

Work Comp/Disability Forms:

Due to the extensive nature of such forms, our office charges a form fee beginning at $10 per page. No forms or records will be released until all account balances have been paid.

SpecOrtho reserves the right to cease treatment on those patients with outstanding account balances. We are happy to work out payment plans in order to keep patient accounts current. Please see our financial manager for special arrangements.

I have read and understand the above Financial Policy, and agree to meet all financial obligations.

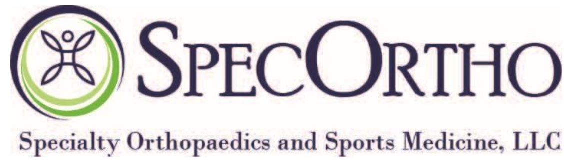
______________________________ ______________________________

Patient signature (or parent, if under age 18) Date

____

Patient Name (printed)

Update 8/1/19



HIPAA Notice of Privacy & Patient Consent Form

This Notice of Privacy Practices provides information about how we may use or disclose protected health information, and how you can get access to this information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change; if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with anyone other than yourself? YES NO

If Yes, please name the person / people with whom we may discuss your medical condition:

____

May we phone, email, or send a text to you to confirm appointment? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

Patient name: ____

This consent was signed by: ____
Patient (or parent if under 18)

Signature: ____ Date: ________________________