

SOMERSET ORTHOPAEDICS, INC.

Patient Information Please complete all lines

PATIENT INFORMATION:

PATIENT NAME: _____
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

NAME OF PARENT/GUARDIAN IF UNDER 18: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

SEX: M/F (circle one) D.O.B. _____ SOCIAL SECURITY NUMBER: _____

MARITAL STATUS: Single/ Married/Widowed/ Separated/ Divorced

FAMILY/REFERRING PHYSICIAN: _____

EMPLOYMENT STATUS: Full-time/ Part-time/ Retired/ Self-Employed/ Unemployed/ Student

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS: _____

PHARMACY: _____

DO YOU HAVE A POWER OF ATTORNEY? Circle Yes/No If yes, please provide the name and number. _____

POLICY HOLDER /RESPONSIBLE PARTY INFORMATION:

Are you the policy holder for your health insurance? Circle Yes/No If yes, please skip this section. If no, please complete the following:

POLICY HOLDER NAME: _____

RELATIONSHIP TO PATIENT: _____ SS#: _____ D.O.B. _____

EMERGENCY CONTACT INFORMATION:

NAME/RELATIONSHIP: _____ PHONE: _____

MEDICAL HISTORY

Are you currently taking any medications? Please circle Yes/No If yes, please provide a list to be copied or use the space provided to write the names and dosages.

Do you have any allergies? (drug, food or environmental) Circle Yes/No If yes, please list your allergies and the reaction.

Please list all chronic medical conditions: (Diabetes, High blood pressure etc...) _____

Have you had any surgeries? Please circle Yes/No If yes, please use the space provided to explain.

Please list immediate family history of chronic medical conditions: _____

Do you use tobacco products? Please circle Yes/No If yes, please explain how much. _____

Do you use alcohol? Please circle Yes/No If yes, please explain how much. _____

Are you using any illegal drugs? Please circle Yes/No If yes, please explain how much. _____

Are you Right Handed or Left Handed (please circle)

Height: _____ Weight: _____

REVIEW OF SYSTEMS

Are you currently experiencing the following: THESE **MUST** BE CIRCLED EITHER YES OR NO

	Circle YES or NO		COMMENTS (DATE, TREATMENT)
Abdominal Pain	Yes	No	
Anemia	Yes	No	
Arthritis (Rheumatoid, Osteoarthritis)	Yes	No	
Asthma/Wheezing	Yes	No	
Bleeding Disorder/Blood Clots	Yes	No	
Burning/Numbness (feet/legs)	Yes	No	
Cancer	Yes	No	
Change in Vision/Hearing	Yes	No	
Chest Pain/Discomfort	Yes	No	
Dental/Gum Problems	Yes	No	
Depression/Anxiety	Yes	No	
Diabetes	Yes	No	
Gallbladder Trouble	Yes	No	
Gout	Yes	No	
Headaches	Yes	No	
Heart Disease/Problems	Yes	No	
Heart Murmur	Yes	No	
High Blood Pressure	Yes	No	
High Cholesterol	Yes	No	
Joint Pain/Swelling/Stiffness	Yes	No	
Kidney Disease/Stones	Yes	No	
Liver Disease	Yes	No	
Mitral Valve Prolapse	Yes	No	
Other Illness/Problem	Yes	No	
Pancreatic Disease	Yes	No	
Poor Leg Circulation/Vascular Disease	Yes	No	
Respiratory Problems	Yes	No	
Scarring Tendency	Yes	No	
Seizures	Yes	No	
Stroke	Yes	No	
Thyroid Problems	Yes	No	
Urinary Infections	Yes	No	
Weight Gain/Loss	Yes	No	

Patient Signature (required)

Date (required)

Physician Signature and Date

Somerset Orthopedics, Inc.
PATIENT FINANCIAL POLICY

Somerset Orthopedics, Inc. (SOI) is committed to providing you with quality and affordable health care. In order to assist our patients in understanding patient and insurance responsibility for services rendered, we have outlined our financial policy below. Your understanding of our financial policy is essential. Please read it, ask any questions you may have, and sign in the space provided. *(A copy will be provided to you upon request.)*

1. **Insurance.** SOI will bill your health insurance carrier(s) if presented with the information and assignment of benefits at the time of service. If you are insured by a plan that we do not accept, payment in full is expected at the time of visit. *(Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.)*
2. **Uninsured Patients.** Self-pay patients are expected to pay for services received in full at each patient visit. (Any self-pay patient requesting elective surgical intervention will be required to pay a deposit prior to proceeding with scheduling the surgery.)
3. **Health and Medical Discount Card Program.** SOI does not accept health and medical discount program cards. Discount medical cards are NOT insurance coverage. SOI will not negotiate discounts or claim re-pricing with these programs.
4. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. *(SOI reserves the right to reschedule non-urgent appointments due to non-payment of co-payment and deductible amounts upon each visit.)*
5. **Non-covered services.** Please be aware that some of the services you receive may be non-covered or not considered reasonable or medically necessary by Medicare or other insurance plans. ***(Notice to Medicare Patients: An Advance Beneficiary Notice [ABN] will be obtained from any Medicare beneficiary or his/her legal guardian prior to providing any services that may be denied by Medicare as not "reasonable and necessary.")*** We try to inform patients when services may not be covered; however, it is the patient's responsibility to understand his/her policy limitations. You are responsible for payment of these services.
6. **Proof of Insurance.** All patients must complete the patient registration process before seeing the doctor. We are required to obtain a copy of your current valid insurance card to provide proof of insurance. We must supply complete and accurate information to your health plan, including your full name, address, phone number, date of birth and Social Security number. Somerset Orthopedics, Inc. respects your private and personal health information. We maintain confidentiality and security as required by Federal HIPAA Guidelines. Our staff is skillfully trained to secure and keep your personal health information private. Incomplete or incorrect information could mean a denial from your insurance provider and you will be held responsible for the balance of your claim when an insurance provider delays or denies payment.
7. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. (Federal laws addressing all insurance companies require that we submit every claim to an insurance company accurately, reporting the actual services performed and the correct diagnosis reason for performing them. It is not legally permissible to change this information just so that a claim can be paid by the insurance company. [*31 U.S.C. §3729 – False Claims Act; Medicare's National Correct Coding Initiative.]
8. **Worker's Compensation.** It is your responsibility to confirm with your employer that Somerset Orthopaedics, Inc. is listed on your worker's compensation panel as a provider for orthopaedic services for your place of employment; if we are not on your panel, we cannot see you for your worker's compensation injury within the first 90 days of the reported injury as you must see a panel physician within that time frame. We will bill for worker's compensation services that have been pre-approved by your employer or worker's compensation insurance carrier. Please give all information needed for billing. The patient is ultimately responsible for any balance due.
9. **Personal Injury (Accident).** If you are a personal injury patient, our office will bill the appropriate insurance company. Please give all information needed for billing. If an attorney is involved, we ask you to provide us with all applicable contact information.
10. **Divorce.** In the case of divorce, the party responsible for the account prior to the divorce remains responsible for the account. The parent authorizing treatment for a child will remain responsible for charges. In a divorce case if a decree requires the other parent to pay all or part of the treatment costs, the authorizing parent is responsible for collecting from the other parent. Ultimately both parents and/or legal guardians are responsible for the account. Any court ordered responsibility judgment must be determined between the individuals involved and cannot be considered by this office.
11. **Coverage changes.** If your insurance changes, please notify us upon your next visit so we can make the appropriate changes to help you receive your maximum benefits.
12. **Nonpayment.** If your account is over 90 days past due for a patient responsibility amount, unless otherwise negotiated, we may refer your account to a collection agency. If this is to occur, SOI reserves the right to discharge you and your immediate family members from the practice. You will be notified by regular and/or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be available to treat you on an emergency basis.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines:

(Signature of Patient/Responsible Party)

(Date)

Somerset Orthopaedics, Inc.

CONSENT TO TREAT, RELEASE INFORMATION TO INSURANCE COMPANIES, ASSIGNMENT OF BENEFITS, AND HIPPA CONSENT

PATIENT NAME (please print): _____

Consent To Treat

I consent to treatment necessary for the care of the patient indicated on this form. I understand this facility may employ physician extenders (physician assistants).

Signature (Patient, Parent, or Guardian)

Date

Consent to Release Information to Insurance Companies and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

Signature (Patient, Parent or Guardian)

Date

I hereby authorize Somerset Orthopaedics, Inc. to apply for benefits on my behalf for covered services rendered by the attending physician or by his/her order. I request that payment from my insurance company be made directly to Somerset Orthopaedics, Inc. I certify that the information I have reported with regard to my insurance is correct. I understand I am financially responsible for this account. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature (Patient, Parent or Guardian)

Date

Consent to Release Information

As stated in our Notice of Privacy Practices, we may use or disclose information about you in order to conduct routine office operations (eg. appointment reminders, general communications). To request restrictions, other than provided for below (**please check those that apply**), please provide your request in writing to the office administrator for consideration.

- Do not leave messages on home phone
 Do not call work number
 Do not speak to family members

Permission to speak only with family member(s) listed below;
Please provide name, relationship to patient, and phone number.

HIPPA Consent (Patient Privacy Law)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent; a copy will be provided to you upon request. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by calling Public Relations at 814-443-5221.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Signature (Patient, Parent or Guardian)

Date