

## Center for Orthopaedic Specialties Patient Registration

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### Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  Male  Female

Marital Status:  Single  Married  Widowed  Divorced  Legally Separated

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Which number do you prefer for our calls to you?: \_\_\_\_\_

Email: \_\_\_\_\_

My appointment is with:  Dr. Richardson  Dr. Solcher

Referred by:  Physician Name: \_\_\_\_\_  
 Family Member Name: \_\_\_\_\_  
 Friend Name: \_\_\_\_\_  
 ER Hospital: \_\_\_\_\_  
 Other \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

### Insured/Responsible Party Information (if different from above)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Relationship:  Spouse  Parent  Other

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Name: \_\_\_\_\_

### Method of Payment

- In-Network Insurance                       Self-Pay (No Insurance Coverage)  
 Out of Network Insurance                 Workers Compensation

In order to file claims with your insurance carrier, please provide copy of current card(s) and answer the following:

Name of Insured: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Effective Date: \_\_\_\_\_

### Financial Policy Acknowledgement

All payments are due at the time of service. If we are providers for your insurance, we will bill your insurance and collect only the patient responsibility amount at the time of office-based services. It is your responsibility to inform us of any changes with your insurance. Many insurance plans have "timely filing deadlines". If we are not provided with accurate information at the time of service, including being provided a copy of the front & back of your current insurance card(s), you will be responsible for payment in full for all services rendered and considered a self-pay patient. Center for Orthopaedic Specialties has preferred provider contracts with a number of major insurance companies. Please contact your insurance company to determine if our practice has a contract with your plan.

*Any financial portion that is the "member's responsibility" such as a co-pay, deductible, or a non-covered percentage will be collected at the time of service. \_\_\_\_\_ (Initial) If, for any reason, it is not paid at time of service, we reserve the right to postpone scheduling any follow-up or future appointments until this obligation is paid in full. \_\_\_\_\_ (Initial)*

**PPO Insurance Plans:** We have agreed to accept discounted rates from plans we participate in, however, all co-insurance and/or deductibles are your responsibility. We will estimate co-payments to the best of our ability. Since the copays are estimates only, we will bill you or credit you for your balance.

**HMO Insurance Plans:** All copays must be paid at each and every visit. If a service provided is not a covered benefit of your plan, you will be responsible for payment in full at the time of service.

**Non-Contracted Insurance Plans:** If we are not contracted with your insurance company you will be asked to pay in full at the time of service. We will be happy to file a claim with your company so out of network benefits can be tracked or we can supply you with a billing copy to attach to a claim form provided by your insurance company so that you can request reimbursement be sent to you.

**Indemnity Insurance Plans:** We will estimate co-pays to the best of our ability. Since the co-pays are estimates only, we will bill you or credit your account for your balance.

**Secondary Insurers:** We file secondary coverage in limited circumstances, including Medicare secondary and if you have secondary coverage with a PPO plan we participate with. In all other cases, we can supply you with a billing copy to attach to a claim form provided by your insurance company so that you can request reimbursement be sent to you.

**Insurance Changes:** If it has been more than 30 days past your effective date and you are first providing us with updated insurance information, there will be a \$25 Service Charge added, per month, due to the amount of time and effort required to correct your account. Also be aware that many insurance policies will not pay for claims that are filed 90 days past the date of service. The patient or their guarantor will be responsible for any claims denied due to timely filing.

**Payment:** We accept cash, money orders, Visa, MasterCard, Discover Card, American Express, debit cards, and personal checks.

**Surgery Prepayment:** All estimated insurance copays and/or deductibles or self-pay estimates for surgery are due in full at least 5 business days prior to the surgery date or the procedure(s) will be postponed.

**Collection Agency:** All balances reaching 90 days past due will be sent to a collection agency. Should your account be sent to a collection agency, you would be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the delinquent balance.

**Returned Checks:** Checks returned to us by the bank will be assessed a \$25.00 returned check fee, in addition to the original amount of the check. You will have 15 days to clear up the outstanding check. If you do not pay the check plus the return fee in the specified time, the check will be sent to a collection agency,. In addition, we will only accept cash or credit card for any future visits.

**Medical Supplies:** All medical supplies provided by our office under \$50.00 and by special order are due and payable at time of service. Medicare and most commercial insurance plans consider these types of supplies to be the patient's responsibility and will provide no reimbursement if they are billed. Our staff can provide you with cost information before you receive them. We will bill insurance if a supply is considered a covered benefit.

**Work-Related Injuries:** If you have been injured on the job, but give our office your regular medical insurance information for us to file, please be advised that we will not retroactively go back and file with worker's compensation. All work-related injuries must be pre-screened by our office, verified, and approved by your adjuster or claims carrier before an initial appointment will be scheduled. You will be required to seek treatment for non-reported on the job injuries with another orthopaedic office if this policy is not followed.

\*\*\*\*\*

Patient Name: \_\_\_\_\_

I authorize medical care and accept financial responsibility for all services rendered. I authorize the release of any medical or other private health information related to all claims for benefits submitted on behalf of myself and/or dependents. I hereby request payment of insurance benefits be made directly to Center for Orthopaedic Specialties, P.A. and authorize the use of this signature on all insurance submissions. I have read and fully understand the financial policies of Center for Orthopaedic Specialties and agree to the terms. I also understand that the terms of these financial policies may be amended by the practice at any time without prior notification.

\_\_\_\_\_  
Patient /Responsible Party Signature Date

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**Privacy Statement Acknowledgement**

I acknowledge Center for Orthopaedic Specialties has provided a Notice of Privacy Practices, both by having a notebook with such policy available and having such policy loaded on it's website, available for my review. If desired, I can request a copy of such notice be available for me to keep. If revisions are made, I understand that it is my responsibility to request a revised copy.

\_\_\_\_\_  
Patient /Guardian Signature Date

### MEDICAL HISTORY

Patient: \_\_\_\_\_

- Yes  No **Are you DIABETIC?**
- Yes  No Do you smoke? If yes, how many cigs per day \_\_\_\_\_
- Yes  No Do you use other tobacco products? What? \_\_\_\_\_
- Yes  No Do you drink alcoholic beverages?  
If yes – how many per week and type \_\_\_\_\_
- Yes  No Females only – Are you Pregnant? Due date \_\_\_\_\_
- Right  Left Are you right-handed or left-handed?

Height \_\_\_\_\_ ft. \_\_\_\_\_ inches Current Weight \_\_\_\_\_ lbs.

Please list any prescription and/or over-the-counter medications you are currently taking for these or any other conditions:

Medication _____	Dosage _____
Medication _____	Dosage _____
Medication _____	Dosage _____
Medication _____	Dosage _____
Medication _____	Dosage _____

**What Pharmacy do you use?** \_\_\_\_\_

Drug Allergies:  Yes, please list  No, No Known Allergies

**List all prior surgeries:**

_____	Date _____
_____	Date _____
_____	Date _____
_____	Date _____

Have you had X-Rays, MRI Studies, or CT Scans? If yes, please list:

_____	Date _____
_____	Date _____
_____	Date _____
_____	Date _____

Have any of your blood relatives had any of the following?:

- Yes  No Rheumatoid Arthritis  Yes  No Parkinson's Disease
- Yes  No Gout  Yes  No Scoliosis
- Yes  No Multiple Sclerosis  Yes  No Bone Cancer
- Yes  No Osteoporosis  Yes  No Systemic Lupus Erythematosus

Patient: \_\_\_\_\_

**Reason for Today's Visit**

- Accident
- Illness
- Work-Related Injury

Date of Injury or Onset of Symptoms: \_\_\_\_\_

How/Where did Injury occur?: \_\_\_\_\_

Reason for Today's Visit?: \_\_\_\_\_

Previous Treatment?: \_\_\_\_\_

**REVIEW OF SYSTEMS**

Please check if you are experiencing any of the following:

**ALLERGIES**

- Asthma
- Latex allergy
- Nickel allergy

**NEUROLOGICAL**

- Numbness of arms/legs
- Coordination problems
- Tingling of hands, feet, arms, or legs

**GENITOURINARY**

- Blood in urine
- Lack of bladder control
- Painful urination

**CONSTITUTIONAL**

- Chills/sweats/fever
- Loss of Sleep
- Weight change

**RESPIRATORY**

- Shortness of breath
- Cough
- Blood when coughing

**DERMATOLOGY**

- Ulcers
- Lesions or Masses
- Dermatitis or eczema

**MUSCULOSKELETAL**

- Pain, weakness, swelling or numbness in:
  - \_\_\_ Hands
  - \_\_\_ Wrists
  - \_\_\_ Hips
  - \_\_\_ Knees
  - \_\_\_ Arms
  - \_\_\_ Legs
  - \_\_\_ Joints
  - \_\_\_ Back – low (lumbar)
  - \_\_\_ Back-middle (thoracic)
  - \_\_\_ Back-neck (cervical)

**CARDIOVASCULAR**

- Irregular heartbeat
- High/low blood pressure
- Poor circulation
- Rapid heartbeat
- Swelling of ankles
- Varicose veins
- Chest pain
- Previous Heart Attack

**HEMATIC/LYMPHATIC**

- Easy skin bruising
- Prolonged bleeding
- Gout
- Anemia
- Blood clots
- Previous transfusions

If so, who is your cardiologist? \_\_\_\_\_

**GASTROINTESTINAL**

- Constipation
- Diarrhea
- Nausea
- Poor appetite

**EAR/NOSE/THROAT**

- Nosebleeds
- Bleeding gums
- Sinusitis

**OTHER CONDITIONS NOT LISTED:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CENTER FOR ORTHOPAEDIC SPECIALTIES USE ONLY:**

Reviewed by: \_\_\_\_\_ Date \_\_\_\_\_