Name _____ Age _____ Sex: M F Birth date _____

Address _____City _____ZIP_____

Home phone _____Work phone _____ Other _____

Height: _____ Weight: _____ Which hand do you write with? **R** **L**

SS# _____ Is this a Workers Compensation claim? Y N

Name of **1st** Health Ins. Company_____ Name on the card: _____their

D.O.B._____ their SS# _____ Name of **2nd** Health Ins. Company_____

Name on the card: _____their D.O.B._____ their SS# _____

Family Physician? _____ Who referred you here?_____

Other physicians/family members/attorney's who I authorize the ongoing release of information: _____

_____

Where did your injury occur? WORK HOME AUTO OTHER

How did you injure yourself? _____

How long have you been having this pain? _____ Do you smoke? Y N _____ packs per day

for _____years. Do you drink alcohol? Y N If YES, how much/often _____

Employer _____Occupation_____

Are you allergic to any medications? Y N If YES, what? _____

Mark all the problems that you have experienced:

_____ Heart (murmur/failure)	_____ Liver Problems	_____ Gout	_____ Cancer
_____ Lung (emphysema/bronchitis)	_____ Kidney Problems	_____ Rheumatoid Arthritis	_____ COPD
_____ Thyroid Disease	_____ Diabetes	_____ Rheumatic Fever	_____ Stroke
_____ Pace Maker	_____ Blood Clots	_____ High Blood Pressure	
_____ Heart Attack	_____ Asthma	_____ HIV/HEP C	_____ Other?
_____ Cardiac Stent	_____ Mitral Valve Prolapse	_____ Hysterectomy	

Previous Surgeries: _____

Have you ever had your bone density tested? Y N If yes, when: _____
May we leave a message at your home with other family? Y N
May we leave a message on your answering machine? Y N

_____ _____

SIGNATURE DATE

Patient Agreement

The Orthopaedic and Sports Medicine Center (OSMC) seeks to provide cost efficient medical care for all our patients. To help us achieve this goal you as the patient, agree to the following for the duration of your doctor-patient relationship with any and all of OSMC'S health care provider's.

You, as the patient, realize that as OSMC cares for your medical needs, various Services will be rendered and/or supplied in the office, the hospital or an ambulatory surgical center. Services are defined as tests, procedures, treatments (either by the Physician or as ordered by the Physician to be performed by the staff, i.e. **Physical Therapists, Physician Assistants, and/or Nurses / Medical Assistants**) surgeries, drugs and soft goods (e.g. braces, splits, casts, slings, boots, etc.) You accept the responsibility to ask questions to insure adequate understanding; after being informed about your care you authorize these Services in accordance with your physician's medical judgment. **There may be additional costs associated with these services, especially if surgery is involved and a PA or RN assists the Physician with the surgery.** These fees are covered by most insurance carriers, but it is always your right to refuse any Service(s).

If you have executed any **advanced directives** (e.g. living will, appointment of a Health Care Representative, life-prolonging procedures declaration, health care durable power of attorney) you will insure that OSMC has a copy of any such document that requires our participation.

In the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**, Congress mandated the establishment of standards for the privacy of individually identifiable health information. We have developed a written statement of our privacy procedures, outlining the ways in which we use and may disclose your protected Health information. You accept the responsibility to ask for a copy of this document, which is available from anyone in the office, and acknowledge that you have received it.

CMS Change Request #6306 requires that we inform you that the physicians at OSMC have a financial interest in the Physician's Ambulatory Surgical Center (PASC) located in Circleville, OH. If you require outpatient surgery while you are a patient of OSMC, you may choose to be referred to a health care entity other than PASC.

Please realize that your **insurance, HMO or employer funded health arrangement (third party payer) is a contract between you and the third party payer.** You are financially responsible for Services rendered. However, we may be able to bill your third party payer or Medicare. In these cases you agree to assign all payments to OSMC. You will remain responsible for any amount of your bills that are not paid by your third party payer. If your third party payer requires referrals, pre-certification or pre-authorization, you accept the responsibility to see these are obtained in a timely manner. If we need to contact your third party payer to appeal an adverse benefit determination, **you authorize us to be your representative**.

Your OSMC physician has a medically appropriate reason for all Services. However, sometimes third party payers consider some Service(s) medically unnecessary, non-covered, experimental/investigative, incidental to another Service or more appropriately included in another Service for billing purposes. In these cases you agree to pay us for those Services. You waive the right to be informed in advance that the Services are medically unnecessary (in the third party payer's opinion) and regardless of any third party payer's opinion **you voluntarily elect to have the Service(s) performed.**

In the event your account is not paid within 120 days, you are responsible for collection costs, including but not limited to an additional 50% collection agency fee, attorney fees and court costs.

If you do not have health insurance coverage, you are required to pay 100% of OSMC's surgical costs prior to your surgery. In this situation, we accept only cash, credit card, or money order.

_____ _____

Patient or Patient's Guardian Date

ORTHOPAEDIC AND SPORTS MEDICINE CENTER, INC.

FINANCIAL POLICY

1. Co-Pays are due at the time of service. The first time a co-pay is not presented, a $10.00 fee will be assessed. On subsequent occasions, your appointment may be rescheduled. Returned checks will result in a $30.00 fee.
2. If OSMC fails to ask for your co-pay, that doesn't necessarily mean that you are not required to pay one. We reserve the right to send bill to your home requesting payment of your co-pay.
3. Un-insured patients must pay in full at the time of service.
4. If we do not have a contract with your insurance company and they do not respond to our billing within 2 billing cycles, you become responsible for the bill in its entirety. We are happy to assist in billing and claim submission; however, it is your responsibility to contact your insurance in the event of non-payment or discounted payments leaving you with a balance due. In an effort to save money, many insurance companies restrict or limit payment indicating that fees are over their "Usual and Customary" fees for this area. We go to great lengths to insure our fees are comparable to that of other offices providing the same quality and level of care. We will not allow insurance companies to set our fees for us.
5. If you have insurance with which we are contracted: we will submit your insurance claims once you provide us with the information necessary to do so. Some insurance companies give us as little as 30 days to submit a bill to them. **If you fail to give us the correct information and your insurance company denies your charge for "past filing" then you are financially liable.** You are also responsible for any amounts not covered by your insurance, including deductibles, non-covered/non-allowed services and any bundled services that do not follow CMS and AAOS coding guidelines. If your insurance denies a service that is appropriately billed, then you are responsible for payment of those services.
6. **We do not belong to all Medicaid Managed Care Plans**. If you are covered by a Medicaid product requiring pre-authorized visits, it is your responsibility to make sure that this is done prior to your appointment. We urge you to contact your MCP to find an in-network physician to avoid incurring medical costs. Any visit denied will be the patient's responsibility. This includes ALL Medicaid products; Amerigroup, Molina, Unison, Caresource, Buckeye Community, among others we are not yet aware of.
7. Worker's Compensation claims less than 2 years old will be accepted on a case-by-case basis. We do request that you give us your health insurance information in the event that BWC denies your claim. We will also send monthly statements to your home to keep you informed of your account status, to make sure you concur with the billed services and because it's just all-round a good idea.
8. **We do not wait on settlement for personal injury cases (auto accidents, injuries incurred on someone else's property, etc.)** In addition, OSMC will not bill your health insurance for personal injury claims.
9. In the event your account becomes delinquent, you will be responsible for any costs involved in collection of your account. These include but are not limited to interest, court costs, attorney fees all which may increase your balance as much as 50%.
10. **We do not get in the middle of custody issues.** The parent who brings in the child for treatment is responsible for the bill. Please do not ask us to track down your former spouse for billing information or make us read your divorce decree.
11. We will not assume responsibility for your medical bill if we are not a contracted provider for your health insurance carrier. This includes occasions where we are mistakenly listed in your Preferred Provider Handbook, on a website, or that we were at one time contacted, but no longer are. Because there are thousands of insurance companies that are constantly merging, breaking-off from parent companies, or offering special plans with unique restrictions for certain businesses, it is impossible for us to know the current status of <u>your</u> particular plan on any given day. Please consult your HR department, agent or your insurance plan. Also, make note of the date and name of the person you spoke to, as it may come in handy in the future. **It is solely your responsibility to understand <u>your</u> plan and <u>your</u> benefits.** Though we are happy to assist you in any way possible and in fact relish any opportunity to argue with an insurance company, if your insurance company declares OSMC was not on plan at the time of your visit, then there is very little we can do to change their mind. Which is why:
12. **OSMC employees are not qualified or permitted to guarantee your insurability.** So please don't be angry when we kindly ask you to contact your appropriate health insurance liaison.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-pays and deductibles, are my responsibility. I authorize my insurance benefits be paid directly to OSMC and I authorize OSMC to release pertinent medical information to my insurance company when requested to facilitate payment of my claim.

_____ _____

Patient over the age of 18 or Responsible Party Date

Narcotic Waiver

I will not receive prescription pain medicine from any other source (physician, hospital, etc) without written consent from OSMC. I will use **no more than 2 pharmacies** to manage my narcotic prescriptions and refills.

I am currently not abusing illicit or prescription drugs.

I have never been involved in the sale, illegal possession, or transport of controlled substances (narcotics, pain killers, sleeping pills, nerve pills, etc.) and **I will not sell or give my narcotics to anyone.**

I will take the medication as prescribed or in smaller doses.

I understand that **if my medication is lost or stolen or inaccessible for ANY reason, I will not receive a replacement** prescription and will have to wait until my scheduled renewal.

Evidence of increasing the amount of medication without communication to an OSMC physician, getting medication from multiple sources, altering prescriptions, selling medication, unapproved use of other drugs (illegal substances, sedatives, or the abuse of non-prescription medication), or any other behavior deemed unacceptable by OMSC will prevent you from receiving any future prescriptions from this office and may result in your dismissal from this practice.

_____
Print Name

_____
Signature

_____
Date

Preferred pharmacy:
Pharmacy street/city:

MEDICATION NAME / DOSAGE	How Often	Ordering Physician

MEDICATION ALLERGIES:
