Office Policies:

Take a proactive role in your health. I understand that I am responsible for my health and that I am entering into this partnership to help achieve the best possible health for me. My physician will make recommendations regarding certain health screenings during my exam appropriate for my diagnosis, based on my examination and radiologic imaging.

Medication Refills: We require that you inform our office at least 48-72 hours prior to needing a medication refill. Our surgeons are not in the office 5 days a week, therefore we require time to coordinate medication refills.

Disability Form Policy: Blank forms will not be accepted, all personal information must be filled in. All forms requiring completion, excluding disabled parking forms but including disability forms, assisted living forms, insurance benefit forms, FMLA forms, leave of absence forms, health assessment forms, and time off work forms that are specific to your employer. (These are not covered by insurance).

- Our staff strives to fill out forms in a timely manner; turnaround time will be 5 business days.
- Forms will not be completed for delinquent accounts; all balances must be paid PRIOR to forms being filled out.
- A fee of $20 will be charge for the completion of disability forms.

Dictated Letters: Letters prepared for third parties will be charged $30. Turnaround time for letters is five business days.

Privacy Preferences

As your health partner, we often have to communicate sensitive, personal health information. This information is protected by federal privacy laws and serves as:

- A basis for planning my care and treatment
- A means of communication between health professionals on my team
- A tool for routine health care operations such as assessing quality and outcomes
- A source of information for creating my bill for health service

Please indicate your privacy preferences below:

1. List the individuals whom may share your personal health information with:

2. List the physical address that we can send your personal health information:
   ☐ Same as Home Address ☐ Different Address _____

3. May we leave personal health information on a voicemail? ___yes ____no

   If "yes" what is the preferred phone number? ☐ Home ☐ Cell ☐ Other _____

In addition, I acknowledge by my signature below that I have the right to be provided a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. Should any further questions, comments, or concerns arise please do not hesitate to contact our offices.

_____ _____ _____

Print Name Signature Date

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Your clear understanding of our practice financial policy is important to our professional relationship. We make every effort to keep our fees reasonable. Payment of your bill is considered part of your overall treatment. In order to keep healthcare costs to an absolute minimum, we have adopted the following policies.

Fees are standard and based on the complexity of your visit. Payment in full is required at the time of your visit and can be made with cash, Visa, MasterCard, American Express or Discover.

Insurance co-payments are due at the time of service. If you are unable to pay your co-payment at your visit, your appointment may need to be rescheduled.

Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. Insurance companies select certain services that they will not cover therefore we can't guarantee payment of all claims by your insurance company. Reduction or rejection of your claim does not relieve you of your financial responsibility.

PLEASE NOTE: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not based on coverage by insurance companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and is considered insurance fraud.

Required at check in:

1. Verify personal contact information
2. Present current picture ID
3. Payment of any outstanding balance
4. Payment of today's visit

We will verify your coverage at each visit. If we're unable to do so, you will be considered self-pay & will be responsible for your visit.

Returned check charge – Non-sufficient funds checks are subject to a $25 fee (in addition to fees from your bank)

Collections charge – Accounts that are not paid within 60 days from the due date may be sent to an external collection agency. In addition to your outstanding balance, a $10 collection fee will be added to cover our cost. In addition, you may be removed from our practice.

INSURANCE INFORMATION

Primary Insurance Name Subscriber Name Subscriber DOB	Secondary Insurance Name Subscriber Name Subscriber DOB

Patient Name:_____ Patient Signature: _____ Date: _____

Registration Form

Last Name First Name Middle		Marital Status Single / Married / Divorced / Widow
Street Address City State Zip		
Birthdate	Sex Male Female	Social Security #
Email Address (for email reminders and newsletters)		Occupation
Home Phone ( )	Cell Phone ( )	Employer
If Minor, Legal Guardian Name:		Guardian Phone ( )
Emergency Contact	Relationship	Phone
How did you hear about our clinic? Family Friend Physician Online Search Health Ins Other_____		Preferred Pharmacy: _____ Phone: _____ Street: _____ City: _____

Primary Care Provider: _____	**City:** _____ **Phone:** _____

Statement of Insurance Eligibility

Many individuals use health insurance to pay a portion of their health services. We require that each individual paying for their health services with health plan benefits sign a form declaring their eligibility as well as acknowledging that they are still responsible for payment of their health services should they be found ineligible for any reason.

I certify and declare that I am eligible for health plan benefit coverage as demonstrated by my presenting of my health ID card and that I have chosen OC Sports and Orthopaedics top provide health services to me.

Furthermore, I certify and declare that if I am found ineligible for health plan coverage, I will be financially responsible for all costs incurred during the delivery of health services and agree to pay these charges to OC Sports & Orthopaedics.

If I do not have health insurance, I agree to pay in full for services rendered on the day I receive them unless payment plan has been previously agreed upon.

_____ _____

Patient/Guardian Signature Date

Health History

Drug Allergies – List all medications you are allergic to	**Reactions:**

Medications – List all medications you are currently taking and the doses	

List any prior surgeries	**Year:**

Family History – Fill in information about your immediate family	
Father: Living Health Conditions: Deceased [Age of death____]	Mother: Living Health Conditions: Deceased [Age of death____]
Sibling: Male Female Living Health Conditions: Deceased [Age of death____]	Sibling: Male Female Living Health Conditions: Deceased [Age of death____]
Sibling: Male Female Living Health Conditions: Deceased [Age of death____]	Sibling: Male Female Living Health Conditions: Deceased [Age of death____]

Social History – Please answer the following questions	
Do you Smoke? Yes No If Yes, How much per day? _____	Do you have prior smoking history? Yes No
On Average, how many alcoholic beverages do you consume per **WEEK**? Zero 1-2 3-4 5-6 7 or more	
On Average, how many caffeinated beverages do you consume per **DAY**? Zero 1-2 3-4 5-6 7 or more	
On Average, how many days per **WEEK** do you exercise? None 1-2 days 3-4 days 5-6 days 7 days per week	
For Females, Last Menstrual Period:	
Do you have any implantable devices? (ex: pacemaker):	
Height:	Weight:

What are your current health conditions/issues/concerns?

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