

CHART #	LAST NAME			FIRST NAME		M.I.	MARITAL STATUS	
							S	M
							W	D
DATE OF BIRTH	AGE	SEX M F	HEIGHT FT: IN:		WEIGHT	SS#		
ADDRESS						HOME PHONE#		
						CELL #		
SPOUSE'S NAME		PARENT'S NAME IF A MINOR			ADDRESS IF DIFFERENT FROM ABOVE			
PATIENT'S EMPLOYER (FATHER'S IF PATIENT A MINOR)					OCCUPATION			
EMPLOYER'S ADDRESS					WORK PHONE #			
SPOUSE'S EMPLOYER (MOTHER'S IF PATIENT A MINOR)					OCCUPATION			
EMPLOYER'S ADDRESS					WORK #			
EMERGENCY CONTACT:		PRIMARY PHONE #			SECONDARY PHONE #			
REFERRED BY:								
FAMILY MD:			ADDRESS:			PHONE #		
LIST ANY MEDICATIONS & DOSAGES YOU ARE PRESENTLY TAKING:								
1. _____			5. _____					
2. _____			6. _____					
3. _____			7. _____					
4. _____			8. _____					
<b>LIST KNOWN DRUG ALLERGIES:</b> _____								
<b>ARE YOU ALLERGIC TO LATEX?</b>			<b>YES</b>			<b>NO</b>		
LIST KNOWN MEDICAL PROBLEMS/PAST SURGERIES								
1. _____			4. _____					
2. _____			5. _____					
3. _____			6. _____					
ADDITIONAL INFORMATION: _____								
THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY BELIEF								
PATIENT'S SIGNATURE _____						DATE: _____		

WS 2008

NAME \_\_\_\_\_

DATE \_\_\_\_\_

*The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.*

**Do you have a history of:**

- |                                |              |                               |              |
|--------------------------------|--------------|-------------------------------|--------------|
| 1. Unexplained weight loss     | YES___ NO___ | 29. Fibromyalgia              | YES___ NO___ |
| 2. Fever or chills             | YES___ NO___ | 29. Stomach/intestinal ulcers | YES___ NO___ |
| 3. Night sweats                | YES___ NO___ | 30. Changes in bowel habits   | YES___ NO___ |
| 4. Skin rashes                 | YES___ NO___ | 31. Urinary frequency         | YES___ NO___ |
| 5. Head trauma                 | YES___ NO___ | 32. Incontinence              | YES___ NO___ |
| 6. Frequent headaches          | YES___ NO___ | 33. Thyroid problems          | YES___ NO___ |
| 7. Double or blurry vision     | YES___ NO___ | 34. Diabetes                  | YES___ NO___ |
| 8. Hearing loss                | YES___ NO___ | 35. Hepatitis                 | YES___ NO___ |
| 9. Ringing in the ears         | YES___ NO___ | 36. Muscle weakness           | YES___ NO___ |
| 10. Nasal congestion           | YES___ NO___ | 37. Leg swelling              | YES___ NO___ |
| 11. Hoarseness                 | YES___ NO___ | 38. Varicose veins            | YES___ NO___ |
| 12. Sore throat                | YES___ NO___ | 39. Blood clots               | YES___ NO___ |
| 13. Swollen glands             | YES___ NO___ | 40. Anxiety                   | YES___ NO___ |
| 14. Breast masses or lumps     | YES___ NO___ | 41. Depression                | YES___ NO___ |
| 15. Wheezing                   | YES___ NO___ | 42. Memory loss               | YES___ NO___ |
| 16. Shortness of breath        | YES___ NO___ | 43. Hernias                   | YES___ NO___ |
| 17. Coughing                   | YES___ NO___ | 44. Menstrual problems        | YES___ NO___ |
| 18. High blood pressure        | YES___ NO___ | 45. Bleeding problems         | YES___ NO___ |
| 19. Heart murmur               | YES___ NO___ | 46. Unusual post-op bleeding  | YES___ NO___ |
| 20. Palpitations               | YES___ NO___ | 47. Anesthesia problems       | YES___ NO___ |
| 21. Stroke                     | YES___ NO___ | 48. Cancer                    | YES___ NO___ |
| 22. Chest pain                 | YES___ NO___ | 49. Malignant hyperthermia    | YES___ NO___ |
| 23. Heartburn                  | YES___ NO___ | 50. HIV or AIDS               | YES___ NO___ |
| 24. Heart attacks              | YES___ NO___ | 51. Metal in eyes             | YES___ NO___ |
| 25. Congestive heart failure   | YES___ NO___ | 52. Brain aneurysm clips      | YES___ NO___ |
| 26. Pacemaker or defibrillator | YES___ NO___ | 53. Cochlear implants         | YES___ NO___ |
| 27. Cardiac stents             | YES___ NO___ | 54. Sleep apnea               | YES___ NO___ |
| 28. Abdominal pain             | YES___ NO___ | 55. Asthma                    | YES___ NO___ |

56. Do you smoke? \_\_\_\_\_ Have you ever? \_\_\_\_\_ How much? \_\_\_\_\_

57. Do you drink alcohol? \_\_\_\_\_ Have you ever? \_\_\_\_\_ How much? \_\_\_\_\_

58. Recreational drug use? \_\_\_\_\_ Explain \_\_\_\_\_

59. Does any family member suffer from any medical problems? \_\_\_\_\_

**THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY BELIEF.**

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DOCTOR SIGNATURE

# HIPAA Notice of Privacy Practices

I, \_\_\_\_\_, understand that as part of my health care, \_\_\_\_\_ originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health care professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services were actually provided, and
- A tool for routine health operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Berkshire Orthopedics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Berkshire Orthopedics reserve the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Berkshire Orthopedics change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

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I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

\_\_\_\_\_  
Patient's Signature (authorized representative signing for the patient)

\_\_\_\_\_  
Date

## FOR OFFICE USE ONLY

- Consent received by \_\_\_\_\_ on \_\_\_\_\_.
- Consent refused by patient, and treatment refused as permitted.
- Consent added to the patient's medical record on \_\_\_\_\_.

PATIENT'S NAME _____	<b>***IMPORTANT: YOU <u>MUST</u> HAVE A REFERRAL FOR YOUR APOINTMENT IF REQUIRED BY YOUR INSURANCE. PLEASE CONTACT YOUR PCP***</b>
PRIMARY INSURANCE _____ ADDRESS _____ _____ GROUP # _____ ID # _____ SUBSCRIBER _____ SUBSCRIBER'S DATE OF BIRTH _____ IS A REFERRAL REQUIRED? _____	SECONDARY INSURANCE _____ ADDRESS _____ _____ GROUP # _____ ID # _____ SUBSCRIBER _____ SUBSCRIBER'S DATE OF BIRTH _____ IS A REFERRAL REQUIRED ? _____
IS SCHOOL INSURANCE INVOLVED? YES    NO DID YOU FILE A CLAIM WITH THE SCHOOL? YES    NO	SCHOOL NAME: _____
<b>***IF THIS VISIT IS COVERED BY WORKMEN'S COMPENSATION OR MOTOR VEHICLE ACCIDENT INSURANCE AND WE WERE NOT INFORMED OF THIS WHEN THE APPOINTMENT WAS MADE, PELASE CONTACT US IMMEDIATELY AT 610-375-4949.</b>	
WAS THIS AN AUTO ACCIDENT: YES NO      DATE OF ACCIDENT: _____ NAME OF INSURANCE COMPANY _____ MAILING ADDRESS _____ PHONE # _____ CLAIM # _____ ATTORNEY _____ PHONE # _____	
WAS THIS A WORK INJURY? YES NO      DATE OF ACCIDENT: _____ WERE YOU INJURED ON THE JOB? YES NO      WAS THE ACCIDENT REPORTED? YES NO INSURANCE CARRIER: _____ CONTACT PERSON: _____ PHONE # _____ ADDRESS: _____ CLAIM # _____	
<b>INSURANCE AUTHORIZATOIN AND ASSIGNMENT: I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS INCLUDING AUTO, MEDICARE, PRIVATE, WORKERS COMPENSATION AND OTHER HEALTH PLANS TO WHICH I AM ENTITLED TO BERKSHIRE ORTHOPEDIC ASSOCIATION. I AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THESE BENEFITS AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. THE ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING AND A PHOTO COPY IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.</b>	
SIGNATURE OF PATIENT (GUARDIAN IF PATIENT IS A MINOR) _____	DATE _____

## **BERKSHIRE ORTHOPEDIC ASSOCIATES, INC., FINANCIAL POLICIES**

Regardless of your insurance coverage, you are always responsible for making sure your bill is paid promptly and in full. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a claim.

Patients should remember that professional services are rendered and charged to the patient, not to the insurance company. Charges are never contingent upon the outcome of pending lawsuits, insurance disputes, or reimbursement from insurance companies.

If your account has an outstanding balance, you will receive a statement each month. Monthly payments are required on accounts.

### **COPAYMENTS, COINSURANCES, AND DEDUCTIBLES**

The patient is expected to present an insurance card at each visit. All co-payments, coinsurances, deductibles and past-due balances are due and payable at check-in. If you cannot pay, you will be asked to reschedule your appointment.

### **SELF PAY ACCOUNTS**

Self-pay accounts are patients who are covered by insurance plans that the office does not participate in, patients without an insurance card on file, patients without referrals or unverified accident cases. It is expected that payment is required at time of all services including surgeries. Office charges will be collected at check-in.

### **NON-PARTICIPATING INSURANCE PLANS**

The financial obligations of patients who are insured by carriers that the practice does not participate with are considered a self-pay account. The insurance will be billed as a non-assigned claim as a courtesy to the patient, with the patient paying the office the amount in full. The insurance company will reimburse the patient on non-assigned claims. If the office receives payment for a non-assigned claim, the patient will receive a refund.

### **PATIENT REFUNDS**

The following criteria must be met prior to issuing a patient refund: the patient does not have any scheduled appointments, there are no outstanding insurance claims on the patient's account, and there are no outstanding patient balances on the account.

### **DIVORCE CASES**

In cases of divorce, the individual who receives the card is responsible for payment of copays, coinsurance, and non-participating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.

### **APPOINTMENT CANCELLATION POLICY**

We understand if you can't keep an appointment, but please call to notify us. There may be a \$35.00 charge to those who do not call to cancel an appointment.

### **CHILD CUSTODY CASES**

The parent with primary custody is usually the parent with whom the child lives and who usually brings the visit. The custodial parent is responsible to pay at the time of service. If the non-custodial parent carries the insurance on the child, the office will bill that insurance company. The office does not get involved with divorce specifics. It is the parents' obligation to work out an agreement themselves or through the court system.

### **REFERRALS**

If your insurance has designated a primary care physician (PCP), you are required to have prior authorization from your PCP prior to your office visit. If this authorization is not provided, you will be asked to reschedule your appointment or pay for the visit at the time of service.

### **WORKERS' COMPENSATION & AUTOMOBILE ACCIDENT CASES**

We will file your claim to your insurance carrier. All claims must be verified prior to services being rendered. If a claim is not verified, you will be considered a self-pay and payment will be collected at check-in. You will be responsible for your bill if your claim is denied for any reason.

### **PAST-DUE ACCOUNTS**

Any time a payment is not received during the last 30 days, your account is considered to be past due. If you are having trouble paying your bill, we can arrange a payment plan for you. Accounts more than 60 days past due will be turned over to collection. Please be advised that you will be charged a collection fee if this happens. Unpaid collection accounts could be reported to a credit bureau.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification on any of the above policies, please feel free to contact us.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE