

Commonwealth Orthopaedics Registration Information 2010

Patient Information

Patient Name Account # _____ _____ Social Security Number _____	Home Telephone # _____ Work Telephone # _____
Address	Cell Telephone # _____
City, State & Zip Code	Patient Sex ___Male ___Female
FOR MEDICARE PATIENTS ONLY: Do you currently reside in a Skilled Nursing Facility? [<input type="checkbox"/>] YES [<input type="checkbox"/>] NO	Date of Birth Age _____ _____
Employment/Student Status: ___Full time employed ___Full time student ___Part time employed ___Part time student ___Unemployed ___Retired	Employer Name & Address _____ _____ _____
Referring Physician _____ Family Physician	Email Address (please print) _____ Married ____ Single ____ Other ____

Financially Responsible Person (if different from above)

Full Name _____ Address _____ City, State & Zip Code _____ Date of Birth _____	Social Security Number _____ Home Telephone # _____ Work Telephone # _____ Cell Telephone # _____
Employer Name _____	Relationship to the Patient (circle one) Self Spouse Child Parent Other

Insurance Company Information

Primary Insurance Company Name	Secondary Insurance Company Name
Address, City, State & Zip	Address, City, State & Zip
Policy Holder Date of Birth	Policy Holder Date of Birth
Policy Holder Employer Policy Holder SSN	Policy Holder Employer Policy Holder SSN
Policy Number Group Number	Policy Number Group Number
Relationship to the Patient (circle one) Self Spouse Child Parent Other	Relationship to the Patient (circle one) Self Spouse Child Parent Other

Date Reviewed _____ Initials _____

Appointment Information:

Patient Name: _____ Account#: _____

Name of Physician to see today: _____

Name of Physician who referred you here today: _____

Body Area being seen for today: _____

Problem?	Y N	Date problem began	_____
Injury?	Y N	Date of Injury	_____
Work Injury	Y N	Date of Injury	_____
Auto Accident	Y N	Date of Accident	_____ State of Accident _____

Emergency Contact Information:

Name _____ Telephone Number _____

Relationship to patient _____

Insurance Authorization and Assignment of Benefits

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to Commonwealth Orthopaedics and Rehabilitation, PC, for anesthesia and orthopedic surgical services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

Signature _____ Date _____

Medicare Patients

If you are covered by Medicare, please read and sign the following:

In Medicare cases, Commonwealth Orthopaedics and Rehabilitation, PC, agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

Signature _____ Date _____

Financial Policy

We accept most insurance plans and will gladly file insurance claims on your behalf. Ultimately you hold the financial responsibility for your account. We ask that you remit any applicable copay, deductible, and co-insurance according to the terms of your insurance contract at the time services are rendered. Furthermore, if you do not pay your copay at the time of your appointment, we retain the right to levy an administrative charge of \$20. Additionally, it is your responsibility to provide any necessary referral information to us that your insurance requires prior to your visit.

If you do have an outstanding balance due, we appreciate prompt payment in full. If you are unable to make payment in full, please inquire about arranging a payment plan. If multiple attempts to collect payment from you are unsuccessful, we reserve the right to turn the outstanding balance due to a collection agency. In addition to the principal balance due, you will also be responsible for any legal or collection agency fees incurred. Any payment made to us in the form of a check that is returned for insufficient funds will incur a \$25 fee per incidence.

Cancellation Policies

Physician Offices: If you fail to provide us with a 24 hour notice of cancellation or fail to keep your scheduled appointment, we reserve the right to charge you a \$30 no show fee.

Physical Therapy: If you fail to provide us with a 24 hour notice of cancellation, you will be charged a \$30 cancellation fee. If you are unable to keep your scheduled appointment and do not notify us, you will be charged a \$50 no show fee. If you schedule an initial evaluation appointment and fail to keep the appointment, you will be charged a \$130 fee.

Surgery: If you fail to provide us with at least 7 (seven) days notice of cancellation or fail to keep your scheduled surgery, we reserve the right to charge you a \$250 fee.

Surgery Policies

If you have surgery performed in one of Commonwealth's outpatient surgery centers, you will receive three separate charges for the services provided: one for the surgeon's fee, one for the facility, and one for the anesthesiologist. If you have surgery in an outside facility (a hospital or non-Commonwealth surgery center), you will receive a bill from us representing the surgeon's fee. In addition, you likely will receive separate bills for services rendered by the hospital, anesthesiology, and possibly radiology and pathology. Please be sure that you understand your insurance coverage and benefits prior to undergoing surgery.

Durable Medical Equipment

There may be occasions when your course of treatment requires the use of an orthopaedic appliance or soft goods to facilitate your rehabilitation. In these instances, we will verify your benefits and file a claim to your insurance company when applicable. In cases where insurance does not cover the required equipment we do require payment in full for the equipment at the time of service.

Consent

My signature below indicates my full understanding and consent to the above described policies. Additionally, I provide authorization to my insurance company to pay any applicable benefits directly to Commonwealth Orthopaedics & Rehabilitation, P.C.

Patient signature

Date

Guarantor signature (if guarantor is not patient)

Date

Acknowledgment of Notice of Privacy Practices and Permission of Disclosure

I acknowledge that I was made aware of Commonwealth Orthopaedic's Privacy Policy and a copy was available for my review.

I authorize the following person(s) access to my protected health information (PHI).

Name	Date of Birth
_____	_____
_____	_____
_____	_____

Patient Printed Name	Date
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Patient Signature

Printed Name of Personal Representative

Signature of Personal Representative

Relationship of Personal Representative to Patient

Notice of Disclosure of Ownership Interest

Commonwealth Orthopaedics & Rehabilitation, P.C. (Commonwealth Orthopaedics) is wholly owned by a subset of the physicians who provide care in the offices of Commonwealth Orthopaedics. The same group of physician owners also owns the outpatient surgery centers and physical therapy clinics associated with Commonwealth Orthopaedics. Because the physicians own the surgery centers and physical therapy operations, they are best able to ensure the highest level of care is provided to you. A schedule of fees related to the services you might receive can be provided at your request. You have the right to request that services be provided at locations other than those described above.

By my signature below, I am acknowledging this Notice of Disclosure of Ownership Interest on the date set forth below.

Patient Signature

Date

Patient's Agent/Representative

Relationship to Patient

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

PATIENT NAME: _____ ACCOUNT#: _____

I hereby authorize Commonwealth Orthopaedics and Rehabilitation, P.C., through its appropriate personnel, to perform or have performed on me, or the above named patient, appropriate assessment and treatment procedures relating to:

I further authorize Commonwealth Orthopaedics and Rehabilitation, P.C. to release to appropriate agencies, any information acquired in the course of my of the above named patient's treatment.

PATIENT SIGNATURE: _____ DATE: _____
(or parent if patient is a minor)

OVER THE COUNTER SALE OF MEDICAL SUPPLIES

There may be occasions when treatment protocols require the purchase of an orthopaedic appliance/soft goods to enhance or progress rehabilitation. In those instances, we do require payment at the time of service.

SIGNATURE: _____ DATE: _____

CANCELLATION POLICY

We understand there are times when you must miss an appointment due to emergencies or obligations to work and family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting a much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a treatment, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance, you personally will be charged a **\$30.00 cancellation fee**, (not your insurance company). If you should fail to show or call, you will be charged a **\$50.00 no-show fee**. Should you cancel less than 24 hours prior to, or fail to show up for your scheduled initial evaluation, you will be held responsible for the evaluation fee.

If time permits, our staff MAY call to remind you of your scheduled appointment. However, should you not receive a reminder telephone call, this will not be accepted as an excuse for a cancelled or no-show appointment.

We appreciate your understanding and cooperation.

PATIENT SIGNATURE: _____ DATE: _____

In addition, if you miss two (2) scheduled physical therapy appointments without giving us the appropriate notice as outlined above, you will be discharged from physical therapy at Commonwealth Orthopaedics. Your subsequent scheduled appointments will be canceled. You will be given a list of outside physical therapy offices in the area to set up further treatment.

PATIENT SIGNATURE: _____ DATE: _____