

**WORKERS' COMPENSATION INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Telephone: \_\_\_\_\_ SS#: \_\_\_\_\_

**EMPLOYER INFORMATION (At time of accident)**

Employer Name: \_\_\_\_\_

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

Employer Telephone: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Occupation: \_\_\_\_\_ Are you currently working? \_\_\_\_\_

If no, last Date of Employment: \_\_\_\_\_

**WORKERS' COMPENSATION CARRIER**

Name of Workers' Compensation Insurance Carrier: \_\_\_\_\_

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

Adjuster: \_\_\_\_\_ Carrier/Adjuster Telephone: \_\_\_\_\_

Carrier Case #: \_\_\_\_\_ WCB #: \_\_\_\_\_

**INJURY INFORMATION**

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_ Place of Injury: \_\_\_\_\_

How Did the Accident Happen? \_\_\_\_\_

Is your case currently controverted? \_\_\_\_\_ Date of Next Hearing: \_\_\_\_\_

Attorney Name: \_\_\_\_\_ Attorney Phone Number: \_\_\_\_\_

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

I clearly understand and agree that all services rendered to me are directly charged to me and that I am personally responsible in the event that my Workers' Compensation benefit is denied. I also authorize Advanced Orthopedics to bill my private health insurance coverage in the event my Workers' Compensation claim is denied or controverted.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_



# Advanced Orthopedics

## PATIENT INFORMATION

Date \_\_\_\_\_ Email \_\_\_\_\_

Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
circle (home/cell) circle (home/cell)

Name \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Last First Middle

Street Address \_\_\_\_\_

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

Mailing Address (if different) \_\_\_\_\_

Sex  Male  Female Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status  M  S  D  W

Race/Ethnicity \_\_\_\_\_ Primary Language \_\_\_\_\_

Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

Referring Physician or Facility \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Have you obtained a referral from your PCP for this visit? \_\_\_\_\_

Where did injury occur?  At work  At school/Sport league  Car accident  Slip & fall  Other \_\_\_\_\_

In case of emergency who should be notified \_\_\_\_\_ Relationship \_\_\_\_\_ Phone No. \_\_\_\_\_

## INSURANCE INFORMATION

Person responsible for account \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last First Middle

Relationship to patient \_\_\_\_\_ Phone No. \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address (if different than above) \_\_\_\_\_

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

Responsible party employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ Business Phone No. \_\_\_\_\_

Insurance Company \_\_\_\_\_

ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

Cardholder's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Cardholder's DOB \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Phone No. \_\_\_\_\_

## SECONDARY INSURANCE

Insurance Company \_\_\_\_\_

ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

Cardholder's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Cardholder's DOB \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Phone No. \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I hereby authorize any insurance benefits to be paid directly to the Physician. I hereby authorize the release of all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges incurred whether or not paid by an insurance company. Interest of 1 1/2 per month (18 annually) may be charged to overdue accounts. Any collection costs (including attorney's fees) will be charged to delinquent accounts and may be reported to credit rating agencies. I realize that insurance assignment (when applicable) is a courtesy extended by Advanced Orthopedics and that I am ultimately responsible for payment of all services rendered. This agreement will remain in effect until revoked by me in writing. A photo copy of this agreement is to be considered as valid as an original.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or Guardian if under 18)



## ADVANCED ORTHOPEDICS

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

### Pharmacy Information

Please list your pharmacy information so that we may electronically prescribe medications for you, when possible:

Pharmacy Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

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

***\*If you do not indicate a preferred pharmacy, we will automatically send your electronic prescription to: Sunrise Pharmacy, located at 285 Sills Rd, Building 8B, in East Patchogue.***

### Current Medications

Please list ALL of the medications you are currently taking:

Medication Name	Strength	Dosage/Day

### Allergies

Please list ALL allergies (drug, food, environmental):

Allergen	Reaction(rash, nausea, shortness of breath, etc)

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

(Parent or Guardian if under 18)

# ADVANCED ORTHOPEDICS

285 Sills Rd, Building 18, Patchogue, NY 11772  
31 Main Rd, Suite #3, Riverhead, NY 11901  
2500 Nesconset Hwy., Building 20-A, Stony Brook, NY 11790

## HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

### **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

#### **Treatment:**

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

#### **Payment:**

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

#### **Healthcare Operations:**

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities may include, but are not limited to, quality assessment, employee review, training, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at

any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### **YOUR RIGHTS**

The following are statements of your rights with respect to your protected health information:

**You have the right to inspect/receive a copy of your protected health information (fees may apply)**

– Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information** – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

**You have the right to request to receive confidential communications** – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You have the right to request an amendment to your protected health information** – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures** – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

### **COMPLAINTS**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.**

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

# ADVANCED ORTHOPEDICS

285 Sills Rd, Building 18, Patchogue, NY 11772  
31 Main Rd, Suite #3, Riverhead, NY 11901  
2500 Nesconset Hwy, Building 20-A, Stony Brook, NY 11790

## Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Patient Name or Legal Guardian (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

You may choose up to 2 people (such as a relative, friend, and/or attorney) to share your medical information with. Any future requests to change this information, must be submitted in writing.

**My protected health information may be released/discussed with the following persons:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Signature of Patient/Legal Guardian: \_\_\_\_\_

Print Name of Patient/Legal Guardian: \_\_\_\_\_

### Office Use Only

*We have made the following attempts to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:*

*Date(s):* \_\_\_\_\_

*Attempt(s):* \_\_\_\_\_

*Staff Name(s):* \_\_\_\_\_

## **Advanced Orthopedics Financial Policy**

Thank you for choosing Advanced Orthopedics as your orthopedic care provider. We are committed to providing you with the highest quality care at a reasonable cost. Acknowledgement and understanding of our Financial Policy must be signed prior to treating with our providers. Your clear understanding of our Financial Policy is important to our professional relationship as it may avoid unnecessary billing issues that may happen as a result of incorrect insurance information and misunderstanding. Please ask if you have any questions at all.

**INSURANCE:** Advanced Orthopedics will file claims to your insurance company. It is the responsibility of the patient to know what your coverage, benefits, and eligibility is. Your insurance carrier makes the final determination regarding eligibility and coverage. You agree to pay any portion not covered by your insurance. Insurance changes must be brought to our attention immediately as the patient will be responsible for all charges not paid as a result of change in insurance coverage.

**SELF-PAY PATIENTS:** All Self-Pay patients and patients who present without proof of insurance are required to pay for their services on the day of visit. Payment plans may be made and a separate agreement will be provided.

**FORMS OF PAYMENT:** We accept Cash, Checks, Visa, MasterCard, Discover, American Express and CareCredit.

**CO-PAYMENTS:** If your coverage requires a patient co-pay, we are obligated by your insurance carrier to collect this at the time of service. Failure to collect co-pays puts both the patient and Advanced Orthopedics in default of the insurance contract. Please be prepared to pay the co-pay at each visit. **Without it, you may be required to reschedule.** There will be a \$10 processing fee for any unpaid co-pay. Chronic non-payment may constitute dismissal from the practice. Some insurance carriers impose more than one co-pay for each visit, e.g. a co-pay for an office visit plus a co-pay for an xray. We may not be aware of your insurance carrier's multiple co-pay policy, and therefore, may bill you for any uncollected co-pay at a later time based on the Explanation of Benefits from your insurance.

**DEDUCTIBLES:** If your coverage includes a patient deductible, you may be asked to pay a portion of your unmet deductible at the time of service. Patients with very high unmet deductibles will be asked to remit a minimum of \$250 at your first visit as a deposit and any remaining balance will be billed upon receipt of the insurance carrier's Explanation of Benefits.

**REFERRALS:** If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and to have it with you at the time of the appointment or prior to. If you do not have your referral, you may have to reschedule your appointment or be considered a Self-Pay patient.

**NON-PARTICIPATING INSURANCE PLANS or "OUT OF NETWORK":** In accordance with a recent law, providers are required to make every effort to inform patients if they may be receiving services Out-of-Network by a non-participating provider. We may provide you with an additional consent form to complete if seeking care from an Out-Of-Network provider. You must also be aware of your own insurance benefit. When in doubt, contact your insurance company directly for clarification. You are responsible for care not covered by your out-of-network insurance plan. Patients treated by any physician, provider or physical therapist at Advanced Orthopedics who do not participate in your insurance plan, are directly responsible for the charges which may not be reimbursed by insurance. We cannot waive copayments, deductibles, coinsurance or other amounts that you responsible to pay under your health plan.

You may also request the estimated charge(s) for expected services. You understand that this is only an estimate and is not a guarantee. Your actual out-of-pocket costs will depend on your eligibility, how much of your annual deductible has been met when the claim is received, the actual services received, the procedure codes submitted by us, your cost-sharing requirements (deductible, coinsurance), or other variables that may impact the cost of services, including a need for additional or different services than originally expected or unanticipated complications. If you have a secondary insurance, or a supplemental accident insurance policy is involved (such as school accident insurance), your secondary insurance coverage will be billed and will most likely further reduce your estimated patient liability or out of pocket expenses.

**FEES:** Advanced Orthopedics uses "Reasonable and Customary" fees, specifically the 80<sup>th</sup> percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by FAIRHealth, a nonprofit organization specified by the NYS Superintendent of Financial Services.

**NO-FAULT/WORKERS COMP CASES:** Patients must report the complete circumstances of the motor vehicle accident or Workers Compensation incident to the front desk staff and complete the appropriate form indicating the date of injury, claim number, insurance company name and address, phone, #, and contact person's name prior to receiving services. We must verify your



insurance claim is open and active for the injury you are being treated for prior to services being started. If the insurance denies the claim and you have private health insurance, it must be billed.

**ACCIDENT/SLIP AND FALL/SCHOOL INJURY/SPORTS LEAGUE CASES:** Patients shall be financially responsible for medical services related to slip and fall, accidents, and school injury or sports league cases. Patients must report the circumstances to the front desk staff and complete the appropriate form indicating the date of injury, claim number, insurance company name and address, phone, #, and contact person's name prior to receiving services. If the insurance denies the claim and you have private health insurance, it must be billed. For school or sports league injuries, the patient's private insurance must be billed as primary, except for Medicaid policies. Therefore, private health insurance information must also be provided before services are rendered. If they do not pay, the patient is responsible for provider's full charges. Liens will not be accepted.

**NO-SHOW APPOINTMENTS:** Missed appointments or No-Shows represent a cost to us, you and to other patients who could have been seen in the time set aside for you. There is a \$25 fee for any broken appointments not cancelled within 24 hours. Missed MRI appointments will incur a \$50 fee and patients who fail to report for scheduled surgery at the hospital will be assessed a \$250 fee if 24 hours' notice is not provided to the office. Patients with multiple missed appointments of any type may be discharged from the practice.

**RETURNED CHECK FEES:** Any returned check from the bank for non-payment or insufficient funds shall result in the patient's account being assessed a \$30.00 fee per check returned.

**CHILD CUSTODY CASES and SECOND PARTY INSURANCE:** In the case of divorce or separation, the parent authorizing treatment for a child/children will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect reimbursement from the other parent.

**MINORS:** Minors under the age of 18 MUST be accompanied by a parent or legal guardian for all services.

**FRACTURE CARE/INJECTIONS/ASPIRATIONS:** Some insurance companies require that fracture care and injection/aspiration billing be performed on a "global" basis. This means that for a pre-determined amount of time, anywhere from 10-90 days, most professional services related to the fracture care or injection/aspiration, are classified by insurance carriers as "surgery", and are included in the initial service. X-rays, injections, aspirations, unplanned casting/splinting, and supplies, are not included within the global fee and are billed separately and any applicable patient out-of-pocket expense including copays and deductibles will be due. Please note that some insurance companies require each visit to be billed separately rather than global billing. Injections, aspirations and fracture care are all procedures listed as "surgical" for billing purposes by insurance companies. Although these services may be provided in the office or emergency room, they may appear on your explanation of benefits as "surgical".

**OUTSTANDING BALANCES:** If you have any outstanding self-pay or insurance designated outstanding balances for co-pays, deductibles and other unpaid out-of-pocket expenses, you will be asked to remit payment at your next visit or you may be required to reschedule your appointment. Chronic non-payment of bills can constitute separation from the practice.

**COLLECTIONS:** If your balance is not paid within 60 days, the account may be forwarded to a collection attorney. Please understand, we do not handle the accounts from this point forward. Their methods are their own, and in addition to the uncollected balance you will be required to pay any fees associated with collections, including interest and court costs.

**THIRD PARTY INSURANCE FORMS (DISABILITY, FMLA ETC):** Your employer, insurance carrier, accident/sickness insurance, etc. may ask you to complete a disability, FMLA, or other form which requires information regarding your care from your physician. A \$15 charge per form is required prior to completion. Please allow up to 10 business days for form completion.

**MEDICAL RECORDS:** Written authorization for release of your medical records is required. Medical record processing is performed by an outsourced company, HealthPort. Once a medical record authorization request is received, HealthPort will send the patient a bill for the copying and mailing of the records prior to releasing records. The law allows up to 30 days to process all medical record requests, however, requests are processed as soon as they are received and usually do not take more than 10-14 days.

I have read the Financial Policies of Advanced Orthopedics and agree to comply with the Financial Policies. In addition, Advanced Orthopedics has my permission to provide medical documentation in order to obtain reimbursement.

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature (or Parent or Legal Guardian)

\_\_\_\_\_  
Date

# Advanced Orthopedics

## Out of Pocket Credit Card Expenses

Date: \_\_\_\_\_ Responsible Party: \_\_\_\_\_

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

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

Home Telephone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

I understand that I am directly responsible for my Out-of-Pocket expenses, including any unmet deductible, coinsurance, copayment, or non-covered services. I authorize Advanced Orthopedics to charge my credit card per my insurance carrier's explanation of benefits for any Out of Pocket Expenses.

I certify that this is my credit card and I am legally authorized to give permission for its use.

This authorizes ONLY Advanced Orthopedics to place charges on my account.

Name on Credit Card: \_\_\_\_\_

Card Holder Address: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Circle: Visa      MasterCard      American Express      Discover

Exp: \_\_\_\_\_ Billing Zip: \_\_\_\_\_ Security Code: \_\_\_\_\_

Is this a Medical Savings Account, HSA, or HRA?     Yes     No

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

### FOR OFFICE USE ONLY

Staff Signature: \_\_\_\_\_ Acct #: \_\_\_\_\_ Date: \_\_\_\_\_