

SOUTHERN WESTCHESTER ORTHOPEDICS AND SPORTS MEDICINE ASSOCIATES, P.C.

Please Print Clearly

Name: _____ **Sex:** M or F **Date Of Birth** _____
Social Security#: _____ **Marital Status:** S M D W
Address: _____ **Apt#** _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
Preferred Method Of Communication: Home() Work() Cellphone() **Email:** _____ @ _____

Emergency Contact/HIPAA Representative

Name: _____ **Phone#:** _____ **Relationship:** _____
Are you currently working: Yes() Full Time() Part Time() () Self Employed Not working ()
Reason: Retired() On Disability() Not Employed() Student()
Employer Name: _____ **Occupation:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Guarantor Information(to whom statements are sent)

Name: _____ **Date Of Birth:** _____ **Sex:** M or F **Relationship to patient:** _____
Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Primary Insurance: _____ **ID#:** _____ **Group#** _____

Policyholder Name: _____ **Date Of Birth:** _____ **Sex:** M or F
Relationship To Policyholder: Self() Spouse/Partner() Child() Other _____

Secondary Insurance: _____ **ID#:** _____ **Group#** _____

Policyholder Name: _____ **Date Of Birth:** _____ **Sex:** M or F
Relationship To Policyholder: Self() Spouse/Partner() Child() Other _____

Pharmacy Name(including any Mail Order Pharmacy): _____

Pharmacy Address: _____ **Pharmacy Phone #:** _____

Family/Primary Physician: _____

Physicians Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone #: _____ **Fax#** _____

Were you referred to our office for a consultation by another physician? ___ Yes ___ No

Referring Physician Name: _____

Referring Physician Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone #: _____ **Fax#:** _____

To the best of my knowledge the above information is complete and accurate.

Signed: _____ **Date:** _____

SOUTHERN WESTCHESTER ORTHOPEDICS AND SPORTS MEDICINE ASSOCIATES, P.C.

David Lent, M.D., Eric Spencer, M.D., Andrew Kirk, PA

Assignment of Benefits

I understand that I am financially responsible to pay Southern Westchester Orthopedics and Sports Medicine, P.C. its usual charges for all services received through Southern Westchester Orthopedics and Sports Medicine, P.C. practices, including any balances or charges not covered by my insurance carrier(s). I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to Southern Westchester Orthopedics and Sports Medicine, P.C., and direct that payment of proceeds be made directly to Southern Westchester Orthopedics and Sports Medicine, P.C..

I authorize the release of medical record information or excerpts thereof to any Insurance company or third party payor for utilization management audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization, per HIPAA regulations.

I authorize Southern Westchester Orthopedics and Sports Medicine, P.C. to obtain/have access to my medication history.

I authorize the healthcare providers of Southern Westchester Orthopedics and Sports Medicine, P.C. to administer treatment as deemed necessary for my care. I certify that no guarantee has been made as to the results that may be obtained from the treatment. This authorization form will remain in effect for 1 year from signature date unless revoked by me in writing and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this authorization form is to be considered as valid as an original.

I also certify that I have read and have been given a copy of Southern Westchester Orthopedics & Sports Medicine Assoc., P.C.'s Notice of Privacy Practices describing how my medical information may be used and disclosed and how I can access my medical information.

Signed: _____ Date: _____

Southern Westchester Orthopedics and Sports Medicine Associates, P.C.
Office Policy(Please read and sign below)

Thank you for choosing our office as your healthcare provider. We are committed to providing the best medical care possible. The following statement explains our financial policy which we ask you to read.

- All patients should provide accurate and complete personal and insurance information prior to be seen by the doctor. Also, you must notify us of any changes to your demographic or insurance information.
- All applicable copays, personal balances, both current and prior are due at the time of service.
- We accept cash, check(endorsed to Southern Westchester Orthopedics and Sports Medicine Associates, P.C.) or credit cards(Visa, Mastercard, American Express and Discover)

Referrals

Please keep track of your referrals. **It is your responsibility** to make sure that you have a current referral on file. Patients will not be seen without a valid referral.

Insurance Changes

You must notify us of any changes to your insurance. Medicare/Medicaid patients, we ask that you contact us **before** enrolling into a Medicare or Medicaid Managed Care Plan since our office may not participate in the plan you choose.

Past Due Accounts

Our office is willing to set up monthly payments for patients who cannot afford to pay balances upfront. However, patients who do not make an effort to pay their outstanding balances will be referred to a collection agency.

Copayments and Balances

By law we **MUST** collect your carrier designated co-pay. Payment for copays is expected at the time of service. If copay balances are not paid on the date of service a **\$15.00 fee** will be charged to your account. This fee is not covered by your insurance, it will be your personal responsibility.

Returned Checks

For checks returned to us unpaid by your bank, **we will charge a \$15.00 fee.**

Forms

There is a \$10.00 fee for each form to be filled out by our office with the exception of NYS disability forms. Certain forms that require extensive information will have a higher fee. All fees must be paid upfront and must be picked up. **Our office will not be responsible for faxing or mailing any forms.**

Xrays: There is a \$10 fee for copies of xray pictures.

Workers Compensation/No Fault

If you register as a private patient and later want your case converted to a Workers' Compensation Claim or a No Fault Claim there will be a **\$350.00** fee to you for all the administrative work involved.

PATIENT SIGNATURE _____ **DATE** _____

SOUTHERN WESTCHESTER ORTHOPEDICS AND SPORTS MEDICINE ASSOCIATES, P.C.

WHICH BODY PART ARE YOU HERE FOR TODAY: RIGHT _____ LEFT _____

WHEN AND HOW DID THIS PROBLEM/INJURY OCCUR? _____

IS THIS INJURY WORK RELATED? YES _____ NO _____

IS THIS INJURY RELATED TO AN AUTOMOBILE ACCIDENT? YES _____ NO _____

DATE OF INJURY: _____

ARE YOU CURRENTLY WORKING? YES _____ NO _____

IF NO, DATE YOU STOPPED WORKING? _____

WERE YOU TREATED IN EMERGENCY ROOM? _____ WHERE _____ WHEN _____

WERE X-RAYS TAKEN? _____ WHERE _____ WHEN _____

PAST MEDICAL HISTORY: _____

DO YOU HAVE ANY ALLERGIES? _____

HEIGHT _____ WEIGHT _____

MEDICATIONS YOU ARE CURRENTLY TAKING _____

EVERYTHING I HAVE ANSWERED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE

DATE

Practice's Requirements

Southern Westchester Orthopedics & Sports Medicine Assoc., PC:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of *04/15/03*.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

PATIENT SIGNATURE _____ **DATE** _____