St.Charles Orthopedics

Referring Physician:_____
Referring MD Phone #:_____
Primary Physician Name #:_____
Primary Physician Phone #:_____

PATIENT REGISTRATION
PATIENT NUMBER:_____

NAME (Last, First, MI)_____ SEX M F
Date of Birth: _____ Age:_____ SS #:_____ Occupation:_____
Street Address:_____ City:_____ State:_____ Zip:_____
Mail Address (If Different):_____ City:_____ State:_____ Zip:_____
Phone#:_____ Cell #:_____ E-Mail:_____ Marital Status:_____
Pharmacy: _____ Address:_____ Phone #:_____
Employer:_____ Address:_____ Phone #:_____
Spouse/Parent/Guardian Name:_____ Phone #:_____
Parents Employer: Mother:_____ Phone #: _____
Father:_____ Phone #:_____
Race_____ Ethnicity_____ Language_____

IN CASE OF EMERGENCY CONTACT:
NAME:_____ Phone #:_____

PRIMARY INSURANCE:
Insurance Company:_____
Insurance Company Address:_____
Policy # :_____ Group #:_____

PERSON RESPONSIBLE FOR ACCOUNT: Last:_____ First:_____ Relationship to Patient:_____
Address:_____ City:_____ State:_____ Zip:_____ Phone #:_____
Insured's Employer:_____
Employer Address:_____ City:_____ State:_____ Zip:_____ Phone #:_____
Date of Birth:_____ SS#:_____ ID #:_____

OTHER INSURANCE
Insurance Company:_____ Policy #:_____ Group #:_____
Insurance Company Address:_____
Insured Name: Last:_____ First:_____ Relationship to Patient:_____
Address:_____ City:_____ State:_____ Zip:_____ Phone #:_____
Employer:_____ Business Phone:_____ Date of Birth:_____ SS #:_____
FOR MEDICARE PATIENTS: IS THIS A MEDIGAP? YES:_____ NO:_____

WAS THIS INJURY RELATED TO EMPLOYMENT, A MOTOR VEHICLE ACCIDENT, SCHOOL INJURY (OR OTHER LIABILITY)_____

WHERE DID INJURY OCCUR? DESCRIBE CIRCUMSTANCES OF INJURY: (DATE, LOCATION, HOW DID IT HAPPEN?)

ARE YOU PURSUING LEGAL ACTION?_____

Assignment of Benefits: I irrevocably assign/authorize to St. Charles Orthopedics the following: a: all of my rights and benefits under Medicare or any insurance contracts for payment of services rendered to me by him, b: all information regarding my benefits under any insurance policy relating to his claims to be released to him, c: to file insurance claims on my behalf including Medigap, if applicable for services rendered to me, d: direct that all such payments go directly to him, e: to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities, f: I authorize the provider to release any information necessary to substantiate a claim. In the event my account goes to collection, I understand that I will be responsible for all collection fees including costs of an attorney. Any questions I may have concerning this assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

PATIENT'S SIGNATURE (If minor, parent or guardian)_____ DATE:_____

Checked By:_____ Date:_____

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St.Charles Orthopedics

INITIAL VISIT HISTORY FORM

Name:_____ Date:_____ Social Sec.# _____

Phone:_____ Age:_____ DOB:_____ Sex: M / F

Name of your Primary Care Doctor:_____

Were you referred by a physician? Y / N: Name: _____ Phone: _____

Reason for today's visit: (briefly state history of problem and when symptoms began)

_____

_____

Problem due to: (check) ____ car accident ____ work-related ____ school injury ____ other

Past Medical History: Have you ever had any of the following medical problems?

Yes	No		Yes	No		Yes	No	
—	—	Stroke	—	—	Cancer	—	—	Thyroid Disease
—	—	Ulcers	—	—	Hepatitis	—	—	Rheumatoid arthritis
—	—	Colitis	—	—	Diabetes	—	—	High Blood Pressure
—	—	Asthma	—	—	Tuberculosis	—	—	Nervous Disorder
—	—	Lyme Disease	—	—	Heart Disease	—	—	Bleeding Disorder
—	—	Arthritis	—	—	Kidney Stones	—	—	Endocrine problems

Explain any positive responses above (and other medical problems not listed): _____

_____

Past Surgical History: (list all surgeries) _____

_____

Medications (list): _____

_____

Allergies (medicines): _____

_____

Review of Systems: Are you having problems with any of the following?

Yes	No		Yes	No		Yes	No	
—	—	Eyes	—	—	Psychiatric problems	—	—	Digestion/Bowel Movement
—	—	Ears, nose, throat	—	—	Joint pain	—	—	Stomach burning
—	—	Lungs/breathing	—	—	Immune system	—	—	Cardiovascular problems
—	—	Recent weight loss	—	—	Urinary problems	—	—	Hematologic/bleeding problems
—	—	Weakness/fatigue	—	—	Chest pain	—	—	Neurologic problems

Explain positive responses: _____

_____

Family Medical History: List medical problems of your relatives (ex. Diabetes, cancer):

Grandparents:_____

Mother:_____ Father:_____

Siblings:_____

Children:_____

Social History: Occupation:_____ Working now? Yes / No / Retired

Do you smoke: Yes /No / Quit? Packs per day: ___ If Quit, years smoked: ___ yrs.

Alcohol use (circle one): Never / Occasional / Daily / Heavy / History of alcoholism

Any history of Drug use (list): _____

(circle one) Married / Single / Divorced / Widowed Live Alone? Yes / No

Are you on a special diet? _____

Do you exercise / play sports (describe briefly)? _____

Completed by: (sign)_____ Reviewed by: Dr. _____

Office Use Only ---------- H:_____ W:_____ T:_____

Revised 5/13

St.Charles Orthopedics

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the facility and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, sexually transmitted diseases, alcohol and substance abuse treatment information, mental health information, and genetic information.

Signature of Patient or Personal Representative	Print Name of Patient or Personal Representative
Description of Personal Representative's Authority	Date
Signature of Facility Representative	Date

EXPRESS AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations. St. Charles Orthopedics may need to disclose my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

If I am unavailable, I expressly permit St. Charles Orthopedics to disclose my protected health information for the purposes of appointment/test/procedure reminders and follow-up to the following individuals:

	(Relationship to patient)
	(Relationship to patient)

I expressly permit St. Charles Orthopedics to disclose my protected health information for the purposes of appointment / test / procedure reminder and follow-up by leaving such information in the form of a message on the following recorded media:

Home answering machine:	Tel. #
Office voicemail:	Tel. #
Other (specify):	Tel. #

Signature of Patient / Personal Representative Parent/Guardian	Date

ST. CHARLES ORTHOPEDICS
FINANCIAL POLICY

Thank you for choosing Orthopedic Associates of Long Island, LLP! We are committed the success of your medical treatment and care. For your convenience, we have answered a variety of commonly asked financial policy questions below. If you have any additional questions about any of these policies, please ask to speak with a Billing Specialist.

Which Plans Do You Contract With?

Your physician/surgeon and their assistant(s) may not be an in-network provider with your health care insurance plan. Please check our website, www.oali.com, to check physician insurance participation and hospital affiliation. If you have any questions, you can contact our billing department to obtain details about your surgery or office visit including the estimated amount of money you may be responsible for paying.

When Do I Pay?

Payment is expected for all copays at the time of the visit. If you do not have insurance or you are covered by an insurance company with which we do not participate, all fees must be paid at the time of visit. We accept payment by cash, Check, VISA, Mastercard, American Express and Discover.

Do I Need A Referral?

If you have a managed care plan with which we are contracted, you may need a referral from your primary care physician. If we have not received a referral prior to your arrival at the office, there will be a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled or offered an opportunity to assume financial responsibility for the services provided that day.

What If My Child Needs To See The Physician?

A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account. Any issues of payment resulting from separation or divorce documents must be resolved by the parents. We will hold the accompanying adult responsible for all charges unless specific arrangements have been made.

What Is My Financial Responsibility For Services?

Your financial responsibility depends on a variety of factors, explained below.

Office Visits and Office Services

HMO & PPO plans which have a contract

If the services are covered by the plan: All applicable copays are due at the time of the office visit. We ask for immediate payment as soon as any deductible is known. If the services you receive are not covered by the plan: Payment is expected in full at the time of the visit. You will be asked to sign a statement authorizing these services.

HMO with which we are not contracted

Payment in full for office visits, x-rays, injections, and all other charges is expected at the time of the office visit. We will provide the necessary information for you to complete and file your claim directly with the insurance company.

Point of Service Plan or Out of Network PPO

Payment for the copay and non-covered services is expected at the time of visit. We will file an insurance claim on your behalf. Coinsurance and deductibles will be billed after we receive payment from your carrier. All balances due will be payable upon receipt of our statement.

Patient Name_____ Date of Birth_____

Medicare (also Medicare HMO Plans)

We will file the claim on your behalf, as well as any claims to your secondary insurance. Payment for copays or any Services not covered by Medicare must be paid at the time of the visit. If you have regular Medicare as primary, and also have secondary insurance, copay will be collected depending on secondary plan. If you have regular Medicare as primary, but no secondary insurance, payment of your 20% coinsurance will be collected at the time of the visit. If Medicare is secondary, you will be billed for any patient responsibility after both insurances have processed.

Worker's Compensation

Prior to your visit, you will need to provide the accident date, claim number, employer information and insurance carrier information. If we have verified the claim with your carrier, no payment is necessary at the time of the visit. Please remember that if the claim is denied, the responsibility for the bill will be yours and payable at our usual and customary fees.

Worker's Compensation (Out of State)

Payment in full is requested at the time of then visit. We will provide you a receipt so you can file the claim with your carrier.

Automobile No-Fault Insurance

Prior to your visit, you will need to provide the accident date, claim number and the insurance carrier information. If the No Fault policy is not in your name, we will need full information on the policyholder.
If we have verified the claim with the carrier, no payment is necessary at the time of the visit. Please remember that if the claim is denied, the responsibility for the bill will be yours and is payable at our usual and customary fees. **If a referral is needed from your private carrier, you must obtain one in the event that your no-fault carrier denies your claim.**

Commercial Insurance: Also known as indemnity, "regular" insurance, or has a percentage coverage (eg. "80/20% coverage".)
We will file a claim to your insurance company as a courtesy. In the event of a denial of any part of the claim, you will need to pay this bill and deal with your insurance carrier directly.

School Insurance: You must submit the original form from the school's carrier. Please bring a copy of the form with you. If you do not have any other insurance, we will bill the school insurance directly. If you have other insurance, the school insurance is secondary and while we will file the claim with your school carrier, you are responsible for payment.

No Insurance (Self Pay)

Payment in full is due at the time of the visit. We will work with you to settle your account. Please ask to speak with our staff if you need assistance.

SURGERY

If your physician recommends surgery, you will have the opportunity to speak with his executive assistant. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it. If you have a commercial plan or are self-pay, she may request a pre-surgical deposit.

Updated 5/19/15

Patient Name_____ Date of Birth_____

Signature _____ Date_____

Catholic Health Services of Long Island

Patient Authorization, Assignment of Benefits & Financial Agreement

Patient Name_____ Date of Birth_____ Effective Date: 01/01/2016

I acknowledge and understand that by signing below, I hereby authorize payment directly to ST. CHARLES ORTHOPEDICS 6 TECHNOLOGY DRIVE, SUITE 100 EAST SETAUKET, NY 11733 www.stcharlesorthopedics.com for services rendered to me, as specified more fully below.

1. **MEDICARE:**
   - I authorize my Medicare benefits to be paid to the Practice for services furnished to me by the Practice.
   - I authorize the Practice to release to the Centers for Medicare and Medicaid Services ("CMS" or "Medicare") and its agents any information needed to determine my Medicare benefits or the benefits payable for related services.
   - I authorize the release of medical information necessary to complete any insurance claim forms and to pay the claim.
   - The Practice accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for any deductible and/or coinsurance payment and payment for any non-covered services. Coinsurance and deductibles for covered services will be based upon the charge determination of the Medicare carrier.
   - I authorize the release of my information to any MediGap or other health insurance carrier I maintain and authorize payment of these secondary insurance benefits to be made on my behalf to the Practice, if possible.
   - My authorization will remain in effect unless I revoke my authorization in writing.

2. **OTHER INSURANCE PLAN PARTICIPATION:** The Practice maintains a list of its contracts with health care service plans ("Plans"), which identifies the Practice physicians who participate in each Plan. A copy of the current list is available from the Practice at the address, telephone number and/or website listed above.
   - I have been informed whether any services rendered to me by the Practice may be provided by a non-participating provider and, if so, (i) that such services by a non-participating provider may result in costs not covered by the Plan and (ii) I am individually obligated to pay the full charges for all such services.
   - I understand that the Practice has no contract, expressed or implied, with any Plan that does not appear on the list.
   - I have been informed that I am individually obligated to pay the full charges for all services rendered to me by the Practice if my Plan does not appear on the list of Plans maintained by the Practice.

3. **NON-COVERED SERVICES**: I understand that each Plan (*i.e.*, HMOs, PPOs) defines what items and services are covered and what items and services are not covered by the Plan.
   - I understand that I will receive an Advanced Beneficiary Notice ("ABN") from the Practice for services that are not or may not be covered by my Plan, and that I will be given the option to accept or decline any non-covered services.
   - I accept full financial responsibility for payment for any potentially non-covered services that I have accepted, as reflected on the ABN, if my Plan determines that such service is not covered. Examples of non-covered services include, but are not limited to, services not specified as being covered by a Plan, services not listed in the benefit summary furnished to patients by the Plan, and/or treatment or tests not authorized by the Plan.
   - I agree to cooperate with the Practice to obtain all necessary authorizations required by my Plan.

4. **RELEASE OF INFORMATION**:
   - I understand that the Practice may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, (1) to any person or corporation that is or may be liable or under contract to the Practice for reimbursement for services rendered, and/or (2) to any health care provider for continued patient care.
   - I understand that the Practice may also disclose on an anonymous basis any information concerning my care that is necessary or appropriate for the advancement of medical science, medical education, medical research, and/or for the collection of statistical data or pursuant to State or Federal law.

5. **FINANCIAL AGREEMENT**:
   - In return for the services provided to me by the Practice, I will pay my account at the time service is rendered to me or will make financial arrangements satisfactory to the Practice for payment.
   - If my account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action.
   - If my account is delinquent, I may be charged interest at the legal rate. I assign to the Practice any benefits of any type under any policy of insurance that insures me or any other party liable to me.
   - If my insurance company or Plan designates copayments and/or deductibles, I will pay such copayment and/or deductible amounts to the Practice.
   - ***I agree to be primarily responsible for the payment of the Practice's bill.***

_____ _____

Beneficiary Signature or Authorized Party Date