ACCT #: PLEASE MAKE CORRECTIONS BELOW:
PATIENT NAME (LAST, FIRST):
ADDRESS :
CITY, STATE, ZIP:
HOME PHONE NUMBER:
EMAIL ADDRESS:
BIRTHDATE:
PATIENTS SSN#:
GUARANTOR NAME:
ADDRESS:
CITY, STATE, ZIP:
PRIMARY CARE PHYSICIAN:
REFERRING PHYSICIAN:
PRIMARY INSURANCE:
POLICY & GROUP #:
SECONDARY INSURANCE:
POLICY & GROUP #:

****

ASSIGNMENT AND RELEASE:

Authorization for treatment, benefits, and release of medical records to: *(please initial)*

__________Employer __________PCP _________Referring MD
__________Physical Therapy _________Attorney _________ DME Supplier

I understand that New Hampshire Orthopaedic Center will, as a courtesy to me, bill my insurance company for services rendered and send a monthly statement to me. I also give permission to release any medical information necessary to my insurance company. I understand that New Hampshire Orthopaedic Center will retain a copy of my drivers' license in an effort to safeguard the use of my health information and insurance against fraud and abuse.
I understand that if services rendered from the initial visit to present are non-referred/non-covered services, I will be responsible for payment. I accept full responsibility for all services that have not been authorized by my physician or insurance company.
I agree to pay my balance with New Hampshire Orthopaedic Center if either my Workers' Compensation claim is denied, my MedPay/PIP is exhausted, my private health insurance does not cover services or if my legal case is not settled in my favor.
I also understand that I am ultimately responsible for any balance on this account. Any patient balance over 90 days will be sent to collection.
I authorize payment of all claim forms directly to New Hampshire Orthopaedic Center. I understand that if my health plan has a copay option, I am responsible to pay at the time of service or my appointment will be rescheduled.

SIGNED:____ DATE:____________________________

FINANCIAL POLICY

(Effective 8/1/07, updated 1/1/10)

Insurance

We participate with most of the major health plans in the area. Please ask us if you are unsure whether we participate with your plan. We will bill your insurance carrier as a courtesy to you; however payment for deductible and co-pay is due at the time of service. This includes all office visits, procedures, and injections. **If you do not have your co-pay with you, your appointment may be rescheduled.** Please remember…Your insurance coverage is a contract between you and your insurance company and not a substitute for payment.

If you are being treated for an injury sustained in a motor vehicle accident (MVA) you will be required to provide proof of health insurance coverage or pay in full at the time of service. We can no longer bill your MVA carrier for services rendered.

Referrals

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

Self pay Accounts

Self pay accounts are patients that have no insurance coverage, or are covered by plans we do not participate with. Payments must be made at the time of service. **If you do not have your payment with you, your appointment may be rescheduled.**

Cancellation Policy (effective 1/1/10)

If you are unable to make your scheduled appointment please notify us at least 24 hours in advance. If we are not notified that you will be unable to keep your appointment you may be assessed a fee. Our providers maintain the right to discharge any patient that is non-compliant with treatment. Therefore if you are to no show 3 appointments or more you may be discharged from the practice with provider's discretion.

Payment Policy

Payments are expected at the time of service. We accept Visa and MasterCard, American Express, Discover, personal checks, and cash. For those that qualify, payment plans may be available for services not covered by insurance when arrangements are made in advance. Please expect to pay any balances due at the time of service. **If you are not able to pay your past due balance at the time of service your appointment may be rescheduled.**

****If you are a surgical patient your portion of payment is due no later than 5 business days prior to surgery. If payment is not received procedure may be rescheduled.****

Delinquent Accounts

In the event that your account should become delinquent, an outside collection agency may be utilized and collections fees assessed to the balance on your account. Delinquent accounts may be reported to the major credit bureaus.

SIGNED:____ DATE:________________________

Durable Medical Equipment (DME) Notice

Durable Medical Equipment, or “DME”, is equipment that is primarily and customarily used to serve a medical purpose, can withstand repeated use, and is appropriate for use in the home. Some examples of DME include walkers, wheel chairs, arm slings, and braces. They are generally special equipment prescribed by physicians for home use, or use outside the physician’s direct supervision, that provides therapeutic benefits or helps patients perform tasks they would otherwise not be able to accomplish. Durable Medical Equipment facilitates ordinary daily activities and improves a patient’s quality of life.

You are receiving this notice because your physician may provide you with equipment classified as DME and that he/she feels is medically necessary to the improvement of your condition. The DME you may receive will be billed to the appropriate party through the format set up in your patient account. Please be sure to contact your insurance company if you have any concerns or questions about the coverage of this equipment under your plan. While the majority of insurance plans cover DME, *your plan may have separate deductibles or restrictions*. While our office makes every attempt to verify your coverage and benefits, we do not make determinations of care based on an out of pocket cost you might encounter.

In the event your equipment malfunctions or is not working properly, please alert your physician at once. We cannot accept returns of any DME products.
SIGNED:____ DATE:_______________________

FEE EXPLANATION

Dear patient:

Your fees for service include your visit with the doctor based on the time and complexity of your condition and treatment provided. In addition, proper attention to your case requires that the doctor spend more time working for you outside your direct visit with him or her. Such time may include:

• Creation of a permanent medical record.
• Review of all laboratory blood test results (e.g.,a biochemical survey and CBC contain 42 separate tests to interpret and file in your chart).
• Review of prior and current x-ray or scan report and personal review with the radiologist of abnormal studies.
• Preparation and mailing of consultation reports and follow-up visits letters and laboratory/scan results to referring physician and any subsequent consulting.
• Follow-up phone call or letter regarding laboratory test results of patients and/or copies of test results when indicated or requested.
•Phone consultation with referring or consulting physicians and other health care providers about your case.
• Other phone calls to and from you and your family members for various reasons.
• Referral letters to any further specialists recommended by the doctor.
• Patient educational materials and medication samples when available.
• Any research done by the doctor about your case. The doctor used medical libraries and computerized medical staff assistance regarding your visit.
• Staff assistance regarding your visit.
• Arranging and coordinating other tests and consultation.
• Calls to and from pharmacies.
• Insurance application forms: health insurance, disability insurance, and life insurance
• Insurance reports: health claims, disability claims to insurance and state, Medicare disability.
• Discussions (sometimes acrimonious) with hospitalization utilization review, insurance companies, or Medicare for ongoing hospitalization.
• Review and management of hospital records.
• Letter of necessity to obtain medical instruments or prescription.
• Letter of necessity for medical services to insurance companies.
• Arrangements for hospitalization with hospital admissions, house staff physicians and consulting physicians, and test/treating.
• Communication daily during admission with nurse’s staff, and attending physicians.
• Tumor registry and other required reports.
• Home health care and nursing facility orders.
• Other reports and forms: jury duty, school, job, sick leave, back to work, communicable disease, etc.

In addition, the doctor participates extensively in continuing medical education, clinical research, teaching, and medical writing to keep up to date on the latest medical advances.
At our office, we feel a strong commitment to keep costs to our patients down. Even so, the cost of billing, postage, photocopying, medical supplies, office supplies, medical journals and textbooks, and other materials keeps increasing. We charge only what we feel is necessary in order to maintain the highest standard of care. We look forward to a lasting and healthy relationship with you.

Please inital: __________

IMPORTANT NOTICE ABOUT YOUR UPCOMING SURGERY:
In an effort to begin preparing for your surgery, our Business Office will be contacting your insurance company to verify eligibility and policy coverage, including any annual deductible and/or co-insurance amounts that will be your responsibility.
Once the Business Office has gathered this information, they will contact you prior to your surgery to discuss your payment arrangements for any portion designated a "Patient Responsibility". Based on the allowable rate for your procedure(s), the Business Office will estimate your personal balance according to your health insurance policy. New Hampshire Orthopaedic Center requires that arrangements for this balance are secured prior to scheduling your surgery, including a credit card authorization for the estimated balance of patient responsibility. At the time the Business Office contacts you, they will advise you of a mailing that you will receive that will require you to turn documents to them in a self-addressed stamped envelope.
New Hampshire Orthopaedic Center makes its best effort to obtain correct information from your insurance carrier, however it is in your best interest to call your carrier and understand your financial responsibilities. Besides the professional fee for the surgeon, you will also incur charges from the facility, as well as the anesthesia department. Any lab work is also billed separately. You may experience varied requirements from all parties involved.
If you are uninsured the Business Office will contact you in the same manner as patients who are insured. The same financial expectations apply.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
My signature below confirms I have reviewed or have been provided the opportunity to review New Hampshire Orthopaedic Center's Notice of Privacy Practices which informs me of the uses and disclosures of my protected health information by New Hampshire Orthopaedic Center and my rights under HIPPA.
I authorize New Hampshire Orthopaedic Center to discuss my confidential health care information as follows:
Please contact me by phone during the day at:

Primary phone number: ________-________-_______ Pls circle: **HOME WORK CELL** Ok to leave message? **YES / NO**

Secondary phone number: ________-________-_______ Pls circle: **HOME WORK CELL** Ok to leave message? **YES** / **NO**

Emergency Contact: (this *may* or *may not* be someone we can share your confidential health information with)

Name:_______________________ **Relationship**:__________________ **Phone**:______-______-______ Ok to share information? **YES /NO**

Furthermore, I authorize New Hampshire Orthopaedic Center to share confidential health information about me with the following individuals:

Name:________________________________ **Relationship**:___________________________ **Phone:** _______-_______-_______

Name:________________________________ **Relationship**:___________________________ **Phone:** _______-_______-_______

Name:________________________________ **Relationship**:___________________________ **Phone:** _______-_______-_______

SIGNED:____ DATE:________________________
PLEASE PRINT NAME IF DIFFERENT FROM PATIENT: ____