Ortho Rhode Island

PATIENT INFORMATION Date:_____

Name_____ DOB_____/_____/_____ ☐ Male ☐ Female ☐ Undefined

Mailing Address _____ City: _____ State: _____ Zip:_____

Billing Address (if different from above) _____

Home: _____ Work: _____ Cell: _____

E-mail Address _____

Preferred Language: _____ Race: _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Marital Status:_____ Social Security Number: _____

Employer/School: ☐Retired _____ Phone: _____

Address:_____ City: _____ State: _____ Zip:_____

MEDICAL INFORMATION

Primary Care Physician: _____ Phone: _____

Pharmacy:_____ Location: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Insurance ID# _____

Secondary Insurance: _____ Insurance ID# _____

Policy Holder's Name: _____ DOB _____/_____/_____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Phone Number: Home:_____ Cell: _____ Work: _____

If patient is a minor:

Parent/Guardian _____ DOB: _____/_____/_____

INJURY INFORMATION

Was this injury/condition incurred at, or a result of:

☐ Work ☐ Auto Accident ☐ Injury at/on public property other than your own ☐ None of these

Do you have a lawyer representing you in regards to this injury? ☐ YES ☐ NO

Lawyer information: Name: _____ Phone _____

By signing below, I acknowledge that I have read a copy of the Orthopedics Rhode Island Notice of Privacy Practices and a copy is available upon request. I have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this Notice, and how I may obtain access to and control of this information. By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.

Signature: _____ Date: _____

☐ For office use only ☐ Insurance card scanned ☐ Photo ID Scanned ☐ Employee Initials_____

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FINANCIAL AGREEMENT

The doctors and staff of the Orthopedics Rhode Island welcome you as a patient and are pleased that you chose us to provide your medical care. We have advised you that we do not participate in all insurance programs, and that certain services in some cases are not covered by insurance. We reserve the right to perform services and utilize certain professional staff to assist us in your care regardless of your insurance coverage.

Our office policy is to receive payment at the time services are rendered. We encourage you to ask questions and make sure you fully understand what your responsibilities are, because you are ultimately responsible for paying for all the services you receive. We are available to explain some of the general parts of how your insurance will cover the services provided by our practice, but only your insurance company will have the specifics of how your plan works.

A finance charge of 1.25% per month (15% annually) may be charged on all past due accounts and a $25 fee will be charged on any returned check. In the event of nonpayment of an account, I understand that I will be responsible for all collection costs, including reasonable attorney fees, incurred for the collection of said balance.

GENERAL CONSENTS/AUTHORIZATIONS

I hereby give Orthopedics Rhode Island consent for those services deemed medically necessary and appropriate by the attending provider.

I request that payment of authorized Medicare, or any other insurance benefits be made on my behalf to Orthopedics Rhode Island for any services provided to me by that group. I understand that any holder of medical information about me may release any information to the Health Care Finance Administration (HCFA) and its agents, in order to facilitate reimbursement for services rendered. I authorize ORI to release information to all parties and/or their representatives listed on my Patient Information Sheet or that may be required to provide or pay for services rendered.

I understand that the above consent/authorizations do not guarantee payment/reimbursement, nor does it release me from any obligation and responsibility for all outstanding charges not covered as a result of, but not exclusive to: co-payments, co-insurance, deductibles, usual and customary schedules, maximum allowances/limits or non-covered services.

I understand that it may be necessary to use a photocopy or facsimile of this assignment and that it is to be considered as valid as the original.

PATIENT'S RESPONSIBILITY FOR MEDICAL CARE

During the course of your orthopedic evaluation and management, your doctor may suggest that you have certain tests done, be evaluated by a physician of a different specialty, or return to this office on a future date for re-evaluation. In consideration of this, and your health, we ask that you keep all scheduled appointments and associated commitments. If you have any questions concerning the recommended management plan, please be sure to have them addressed during your visit, or by phone, should questions come up after your visit. The continuity of your care often depends on your full cooperation and open communication. If, for some reason you cannot proceed with your doctor's recommendations, please let us know as soon as possible. Your doctor relies on your honest and complete feedback and will respect your decision. It is important that you understand the consequences of not following through with recommended testing or scheduled appointments. The field of medicine, especially Orthopedic Surgery, often involves problems, which, if not properly addressed, can be life threatening. Your signature below acknowledges your understanding of the importance of proceeding with the management plan as recommended and the subsequent consequences of not doing so.

Patient/Guarantor:

PRINT NAME:_____SIGN_____

DATE:_____

Individual's Signature indicates that they have read the above statement and agree to accept its terms and conditions.