

PATIENT INFORMATION

Patient's Name: _____ Suffix (Jr/Sr/III) _____ Date of Birth: _____ Age: _____
 Home Address: _____ City: _____ State: _____ Zip: _____
 Mailing Address (if different from above): _____
 Home Phone: _____ Cell Phone: _____ E-mail: _____
 Soc. Sec. #: _____ Preferred Language: English Spanish Other: _____
 Occupation: _____ Employer: _____
 Employer's Address: _____ Work Phone _____
 Race: American Indian/Alaska Native Asian Black/African American Caucasian Greek Hispanic Indian
Multi-Racial Native Hawaiian/Other Pacific Islander Spanish American Other Race Prefer Not to Answer
 Ethnicity: Not Hispanic/Latino Hispanic/Latino Prefer Not to Answer
Spouse's Name: _____ **DOB:** _____ **Soc. Sec. #:** _____
 Phone: _____ Employer: _____ Work Phone: _____
Emergency Contact: _____ Relationship: _____ Phone #: _____

PARENT / GUARDIAN INFORMATION IF PATIENT IS A MINOR

Father's/Guardian's Name _____ **DOB** _____ **Soc. Sec. #** _____
 Address (if different from patient) _____
 Home Phone: _____ Cell Phone: _____
 Employer _____ Work Phone: _____
Mother's/Guardian's Name _____ **DOB** _____ **Soc. Sec. #** _____
 Address (if different from patient) _____
 Home Phone: _____ Cell Phone: _____
 Employer _____ Work Phone: _____

HEALTH INSURANCE – PLEASE PRESENT YOUR CARD(S) TO RECEPTIONIST

Primary Insurance _____ **Policy ID#** _____ **Group #** _____
 Effective Date: _____ **Subscriber's Name** _____ **Relationship to Patient:** _____
 Subscriber's Soc. Sec. # _____ **DOB** _____ Sex: Male Female
 Address (if different from patient): _____ Phone: _____
Secondary Insurance _____ **Policy ID#** _____ **Group #** _____
 Effective Date: _____ **Subscriber's Name** _____ **Relationship to Patient:** _____
 Subscriber's Soc. Sec. # _____ **DOB** _____ Sex: Male Female
 Address (if different from patient): _____ Phone: _____
***MEDICARE PATIENTS:** Are you currently in a Skilled Nursing Facility or receiving Home Health services?
Yes No Facility/Agency Name: _____

ACCIDENT INFORMATION (IF APPLICABLE)

Date of Accident: _____ Worker's Compensation; or Auto Accident; or Other State: _____
 Part of body injured _____ Describe how you were injured: _____
 Employer (at the time of accident) _____ Phone _____
 Insurance Carrier _____ Phone _____
 Claim / Policy # _____ Name of Adjuster _____

PATIENT FINANCIAL POLICY

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to us. Please ask if you have any questions about your financial responsibility. YOU WILL BE ASKED TO ACKNOWLEDGE AND SIGN THIS POLICY AT YOUR FIRST VISIT.

****New Patients may be charged \$50 for “No Show” appointments** (if you don’t call ahead to cancel); this fee must be paid prior to any future appointments being made.

INSURANCE PARTICIPATION: As the patient/insurance subscriber, you are ultimately responsible for knowing what your insurance plan covers and which providers are in-network with your insurance. Please contact your insurance company prior to your first appointment to verify whether Winchester Orthopaedic Associates participates with your plan. Please notify us of any insurance changes as soon as possible. Contractual agreement with your insurance requires that we collect your designated co-pay at each office visit.

REFERRALS: If your insurance plan requires a referral or pre-authorization to see a specialist, please obtain the referral or authorization from your primary care physician prior to your scheduled appointment and have it faxed to our office, or bring it with you at the time of the appointment. If you do not have your referral or pre-authorization at the time of your appointment, you may be required to reschedule. Obtaining this information is your responsibility; failure to obtain the necessary referral may result in insurance claim denial, and the resulting account balance will be the patient/guarantor responsibility.

NON-PARTICIPATING INSURANCE: As a courtesy, we will submit charges to your insurance company as a non-participating provider. The insurance co-pay is expected on the day of your appointment **before** being seen by the provider. Any outstanding balance will be your responsibility.

SELF-PAY: If you have no insurance coverage, you will be considered self-pay. If you are a new patient, a minimum payment of **\$150.00** is expected on the day of your appointment **before** being seen by the health care provider. This fee will go toward any services rendered at the first visit; any balance remaining must be paid prior to your next visit.

SURGERY FEES (Self-Pay): Payment of half of the estimated surgical fee is expected prior to surgery. The remaining balance is expected to be paid off in three (3) months. Please ask to speak to an account representative if you have questions.

SURGERY DEPOSIT: \$350 must be paid before elective surgery is scheduled. Exceptions may apply based on insurance plan.

MEDICARE: We will submit to Medicare for the Medicare allowed amounts. You will be responsible for the payment of the deductible and co-insurance.

AUTO ACCIDENT CASES: We do not file auto insurance. You will be financially responsible for services related to an auto accident. Without providing your health insurance, you will be considered a Self-Pay patient.

WORKER’S COMPENSATION: It is your responsibility to provide Winchester Orthopaedic Associates with: date of injury, claim #, insurance company address, phone #, and contact person, prior to evaluation by the physician.

CHILD CUSTODY CASES: The individual that signs for services will be responsible for all charges and outstanding balances.

RETURNED CHECK FEES: Our returned check fee (for insufficient funds) is **\$35.00**.

UNPAID ACCOUNTS: Accounts unpaid for three (3) consecutive months may be referred to a collection agency.

METHODS OF PAYMENT ACCEPTED: Cash, Personal checks, MasterCard, VISA, American Express, Discover and debit cards.

AUTHORIZATIONS: This office will **make every attempt** to obtain pre-authorization for tests, procedures, surgery or physical therapy initiated by our health care providers. It is important for you to **contact your insurance company at least two days before your scheduled procedure** and verify that all pre-authorization requirements have been satisfied. **Authorization may take up to 14 business days.** Delays in obtaining authorization or certification are often beyond our control.

***PATIENT / RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____**

PATIENT NAME (PRINT): _____