THE HIRSH CENTER
for ARTHRITIS and SPORTS MEDICINE

New Patient Registration

MRN ___________

General Information

Name ____ Date of Birth _________________ Sex: M / F

Email ____

Social sec # _________________________________ Marital status: Single / Married / Divorced / Widowed

Local address ____ Community Name ________________________

City _____________________________________ State _____________ Zip _____________________

Home phone _______________________ Work phone _______________________ Cell phone ____________________

(*Disclaimer: By providing your cell phone number, you are authorizing our office, The Hirsh Center, to send you text messages to confirm and remind you of your upcoming appointments. You may opt out of this service at any time.*)

Secondary address ____ Community Name ________________________

City _____________________________________ State _____________ Zip _____________________

Pharmacy name _________________________ Phone _______________________ Fax ________________________

Employment status: employed / not employed / retired / student

Employer: ______________________________ Occupation __________________________________

Primary Insurance

Insurance name ______________________________

Policyholder's name ____________________ Policyholder's Date of Birth __________ Relationship to insured ____________

Secondary Insurance

Insurance name ______________________________

Policyholder's name ____________________ Policyholder's Date of Birth __________ Relationship to insured ____________

Doctor Information

Primary Care Physician _______________________________________ Phone _______________________________

Referring Physician ____ Phone ______________________________

Race: choose one

___ American Indian/Alaskan Native
___ Asian
___ Black or African American
___ Caucasian White
___ Multiracial
___ Native Hawaiian or other Pacific Islander
___ Refused/Declined

Language: choose one

___ Declined to Specify
___ English
___ Sign Language
___ Spanish

Ethnicity: choose one

___ Declined to Specify
___ Hispanic or Latino
___ Not Hispanic or Latino
___ Refused / Declined
___ Unknown / Not Reported

Accident Information

Is visit related to an auto accident or work-related accident? Y / N

*****Disclaimer: The Hirsh Center is unable to treat any <u>new patient</u> whose visit is related to an auto or work-related accident*****

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Emergency Contact

I authorize the physicians and/or staff of The Hirsh Center to communicate with the following individual about my health care which may include information about my medical diagnoses, insurance eligibility and changes, appointments, and/or medication changes.

Emergency Contact ___________________________ Relationship _____________ Phone ___________________

Financial Responsibilities

- I understand that I am financially responsible for services rendered to me by the physicians and/or staff of The Hirsh Center. This includes providing current insurance information needed to submit claims to my insurance plan(s) on my behalf. The Hirsh Center will submit claims only to primary and secondary insurance policies.
- I understand that I am responsible for paying my co-pay, co-insurance or deductible at the time services are rendered.
- I understand that if I have a high deductible plan, it is required that I either keep a credit card on file or put down a $250 (cash or credit card) deposit prior to seeing the doctor and pay the additional balance for services rendered at time of check out.
- I am aware if I have Medicare with no secondary insurance, I am responsible for keeping a credit card on file or paying the remaining 20% when services are rendered.
- I understand that failure to provide current insurance information will result in my becoming responsible for payment of services rendered to me.
- For services that require orchestrating receipt of specialty pharmacy medications, submitting prior authorization requests and enrolling and renewing in patient assistance programs, a $50 Care Coordination Fee will be charged prior to the commencement of applicable services.
- I authorize the physicians and/or the staff of The Hirsh Center to act as my designated representative as part of the appeal process should this be required by my insurance plan(s)
- I authorize my insurance plan(s) to communicate with the physicians and/or staff of The Hirsh Center in all aspects of the submission and appeal process.
- I understand that The Hirsh Center will put forth its greatest effort in collecting payment from my insurance plan(s). If they have exhausted all efforts, I will be responsible to pay for the services received.

Collections and Associated Fees

I understand services rendered to me by the physicians and/or staff of The Hirsh Center are my responsibility. Refunds which may be due will be returned via check mailed to your address on file. I understand that any account balance that is not paid within 60 days may begin our collection process. Balances remaining unpaid by 90 days may be reviewed and sent to a collection agency. If my account is sent to a collection agency, I will be responsible for all costs relating to the collection of my debt. This could include, but not be limited to, an additional 20% to 40% in fees assessed by the agency to which my account is sent.

Special Accommodations

If you require a special accommodation for your appointment, you or your representative must notify The Hirsh Center at least one week (7 days) in advance of your appointment. If you are a new patient, notice must be provided at the time your appointment is scheduled. Under the American with Disabilities Act, “Providers are responsible for incurring all costs incurred for providing reasonable aid and cannot pass the charge onto the patient or their insurance company.” **However, if you have requested an accommodation and you either do not show or do not cancel 24 hours prior to your appointment, you could be responsible for the cost incurred by the third party responsible for providing these services to you.**

By signing below, I acknowledge that I have read and understand all the above:

Patient signature: ____ Date: _______________

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ACKNOWLEDGEMENT OF NOTIFICATION OF THE HIRSH CENTER NOTICE OF PRIVACY PRACTICES

We are required to make available to you a copy of our Notice of Privacy Practices and provide you with a copy if requested. Please sign this form to acknowledge that you have been advised and made aware of our Notice of Privacy Practices.

Patient Name (Please Print): __________________________________

Patient Signature: ___________________________ Date: _____________________________

You may refuse to sign this acknowledgement.

Reason for refusal: ____

The Hirsh Center Staff Signature:

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