THE HIRSH CENTER
for ARTHRITIS and SPORTS MEDICINE

New Patient Registration

General Information

Name _____ Date of Birth _____ Sex: M / F

Email _____ Marital status: Single / Married / Divorced / Widowed

Social sec # _____
(SS# is required patient assistance programs)

Local address _____ Community Name _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____Cell phone _____
(*Disclaimer: By providing your cell phone number, you authorize our office, The Hirsh Center, to send you text messages to confirm and remind you of your upcoming appointments. If you do not have text capability, The Hirsh Center will call the number on file. You may opt out of this service at any time.)*

Secondary address _____ City _____ State _____ Zip _____

Pharmacy name _____ Phone _____

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 Pacific Islander
___ Refused/Declined

Ethnicity: choose one
___ Hispanic or Latino
___ Not Hispanic or Latino
___ Refused/ Declined

Language: choose one
___ English
___ Spanish
___ Sign Language
___ Other
___ Declined to Specify

Accident Information

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

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

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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.
- 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 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.**

Patient Expectations

We have a safe and healing environment. Foul language, aggression, and disrespect towards our staff is not acceptable. Verbal threats or inappropriate behavior will not be tolerated and could result in termination from our practice.

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: _____