Winchester Orthopaedic Associates, Ltd. ***REGISTRATION & AUTHORIZATION***

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 ____________________

ASSIGNMENT AND RELEASE OF INFORMATION / CONSENT TO TREAT

Assignment and Release of Information: I hereby authorize Winchester Orthopaedic Associates, Ltd., to release any information acquired in the course of my examination and treatment to the insurance company. I also authorize payment directly to the physician. I understand that in the event that my account is referred to a collection agency, I will be responsible for the balance plus an additional charge of 33.3% and any associated attorney fees, if applicable. ***By signing below, I recognize and accept responsibility for any balance remaining after payment of benefits.***
Consent to Treat: I also hereby request and consent to treatment and services reasonable and proper by today's standards provided by a practitioner of Winchester Orthopaedic Associates, Ltd., and any employee acting under the practitioner's orders.

______________________________ ______________________________ ____________
Signature of Patient/Responsible Party Relationship to Patient Date

HIPAA / PRIVACY AUTHORIZATION AND ACKNOWLEDGMENT

Winchester Orthopaedic Associates is very concerned about the protection of your health information. Federal law requires us to have a signed privacy statement on file for every patient. This law is intended to protect the privacy of your medical records. In order to serve you, we must have an existing Privacy Acknowledgement on file.

I have been given the opportunity to review the HIPAA Privacy Notice. **Patient/Guardian Initials: ___________**

____ I do; ____ I do NOT - give permission to leave detailed messages on my answering machine regarding instructions for **surgery, test results, billing and/or insurance issues** or other pertinent information from Winchester Orthopaedic Associates, Ltd.

Patient/Guardian Initials: ___________

____ I do; ____ I do NOT - give permission to leave detailed messages on my answering machine regarding **appointment reminders.**

Patient/Guardian Initials: ___________

Preferred contact method for appointment reminders: ☐Home # ☐Cell # ☐Work #

Please list any persons you would like to authorize to have access to your billing, appointment, or health information:
Name *Relationship* *Phone #* *Date of Birth*

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____
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Patient Name: ____________________________________ Date of Birth:__________________

Name of Legal Guardian if patient is a minor: ____

Signature of Patient or Legal Guardian:________________________________ Date: __________

PRESCRIPTION MONITORING PROGRAM (PMP) NOTICE

Winchester Orthopaedic Associates, Ltd. participates in the Prescription Monitoring Program. This program collects data on prescription medications dispensed by pharmacies to promote the appropriate use of controlled substances.

Patient/Guardian Initials: ____________

FOR OFFICE USE ONLY:

For use by WOA personnel if unable to obtain a written acknowledgement of receipt of the HIPAA Privacy Notice:
I have made a good faith effort to obtain a written acknowledgment of receipt of the HIPAA Privacy Notice from the above named patient, but was unable to for the following reason:
__Language Barrier __Patient cannot read __Patient objects __Unable to sign __Other:________________

Employee Name: ________________________________ Date: ______________________

Physical Therapy

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.

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 Physical Therapy, LLC** 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 physical therapist, please obtain the referral or authorization from your primary care physician prior to your scheduled appointment and 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.

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 **$125.00** is expected on the day of your appointment **before** being seen by the therapist. If you are unable to pay this fee, please contact the billing office **prior to** your scheduled appointment. You may be required to sign a self-pay agreement.

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

> *MEDICARE PATIENTS – RECEIVING HOME HEALTH SERVICES: **If you are receiving Home Health services for ANY reason, please inform our receptionists prior to your first appointment.** Medicare may require you to receive physical therapy services through your Home Health provider instead of receiving outpatient services through our clinic. We may be able to assist you in coordinating this service.

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 our office with: date of injury, claim #, insurance company address, phone #, and contact person, prior to evaluation by the therapist.

CHILD CUSTODY CASES: The individual that signs for services will be responsible for all outstanding charges and 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 treatment initiated by our health care providers. It is important for you to **contact your insurance company at least two days before your scheduled appointment** 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): ____