HIPPA OMNIBUS RULE for

Charlotte Orthopaedic Clinic, P.A.

PATIENT ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY AND/CONSENT/LIMITED AUTHORIZATION RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we MAY NOT BE ALLOWED to process your insurance claim.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

_____ _____

Please **print** your name Please **sign** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

HOW WOULD YOU LIKE TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐Proper Sir Name ☐Other:_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step-parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE COVERED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFORMATION** ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

☐ Text Message ☐ **Any of the Above**
☐ Email ☐ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgment Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

_____

Signature of Privacy Officer

CHARLOTTE ORTHOPAEDIC CLINIC

OFFICE AND FINANCIAL POLICIES

We would like to thank you for choosing Charlotte Orthopaedic Clinic, P.A. (COC) as your medical provider. To keep you informed of our current office and financial policies, we ask that you read, initial and sign our financial acknowledgment prior to any treatment.

Insurance: Please bring your insurance card with you at the time of your appointment. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. **The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier.** If you do not have your co-pay at the time of your visit, you must provide us a written waiver from your insurance carrier specifically authorizing COC to waive this obligation.

HMO or POS: For POS and HMO insurance plans that we participate in, your insurance carrier requires that you obtain a referral from your Primary Care Physician (PCP) before receiving services. Please bring that referral with you. Any services received without a referral or proper authorization will be your responsibility.

No Insurance: Payment will be due at the time of service. Self-pay patients will be required to bring **$250.00 - $300.00** at the initial appointment if not being seen for fracture and will be asked to make payment arrangements for the balance. Extended payment arrangements are available if needed. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress. If you are unable to pay your balance in full, you will need to make prior arrangements with our Billing and Collection Coordinator.

Auto Accident Injury: If your injury is due to an automobile accident, we request that you provide us with any information that will assist us in getting your medical claims paid. This information may include: a copy of the police report; a copy of your auto insurance names; and information on other parties involved Payment for any services that we provide will be your responsibility.

Canceled Appointments: If you are unable to keep your scheduled appointment; please call our office within 24 hours to reschedule your appointment, as this will enable us time to use your slot for another patient.

Liability Injury: If your injury is a result from another party's negligence, we request that you provide us with any information that will assist us in obtaining reimbursement for the services rendered to you. This information may include: a copy of the accident report listing claim number and responsible part medical coverage and/or attorney information Payment for any services that we provide will ultimately be your responsibility if not paid by promptly another party.

Worker's Compensation: If your injury is due to an accident in your work place, please be sure to contact your employer and inform them of your injury. We will need to receive authorization from your employer before we can process any of your medical claims. Failure to properly report this injury to your employer may result in your claims being denied. Denied claims will be your responsibility.

Return Checks: A $35.00 charge will be added to your account for any check returned by your bank for any reason.

Disability or Insurance Forms: There **may be** a charge of $25.00 for the completion of medical forms. Pre-Payment is required prior to the form being completed. Please allow 5-7 business days for the completion of these forms. If you would like the forms mailed or faxed to you or your insurance company, please provide that request in writing at the time of payment.

Medical Records:. COC charges $1.00 a page for the first 25 pages and .25 thereafter for copies of your medical records, and a reasonable fee for the actual cost of mailing, shipping or delivery. Records are retained until payment is received. We only release records for visits and tests done at our facility.

Diagnostic Imaging: For any, diagnostic imaging request, the fees are no more than $10.00 per copy and reasonable fee for the actual cost of mailing, shipping or delivery. Films/disks are retained until payment is received.

Fracture Care: Fracture Care is billed out as a “packaged” service which includes the following: Evaluation, the **first** cast or splint application, and 90 days of post-operative follow up care from the date of the fracture. There are some services that we bill separately which include: x-rays, all casting supplies, replacement cast applications, Durable Medical Equipment (DME), evaluations for any additional problems or injuries, and treatment of complications. Fracture care is listed as a “Surgical” procedure for billing purposes. This does not mean that we are implying that you will have an operation. This is how the CPT (Current Procedural Terminology) book organizes this service for ease of use by both the insurance companies and the physicians. Please note your insurance company may cover these services for fracture care differently than office visits. Therefore, your services may be paid as a surgical procedure, with deductible and coinsurance guidelines applied. If you have any questions or concerns, please contact our Billing office at 941-625-0984, Ext 114.

OVER

Minors: If the patient is a minor, he/she must be accompanied by Parent/Legal Guardian for each office visit. Minor Consent must be completed and signed by Parent/Legal Guardian.

Missed Appointments: COC requires 24-hour notice of appointment cancellation. Appointments missed and are not previously canceled **may be** charged a fee of $20.00.

Outstanding Balance Policy: It is our office policy that all past due accounts be sent two statements. If payment is not made on this account, a letter will be sent to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

BILLING INFORMATION

As a courtesy to our patients we will file your insurance claims from our office. In order to do this we will require information from you. We ask that at the time of making your appointment, you inform the customer service representative of the type of insurance you have. Additional information will be required for those injuries or illnesses that are a result of a work or auto accident or if your case is under litigation.

We will need all your demographic and insurance information prior to your appointment. We ask that at the time of your appointment you bring your insurance card and a photo ID as well as any other information that will assist us in making sure that your claim is filed correctly.

At the time of service you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and non-covered services or items received. For your convenience we accept cash, checks, and credit cards (Visa, MasterCard) Care Credit and money orders. CareCredit is a monthly payment plan that allows you to pay over time with convenient low minimum monthly payments. You can contact them directly at 1-866-834-3207.

Although we are contracted with several insurance companies, it is your responsibility to make sure that our physician is in your plan. Also, if your insurance requires a referral for any services or products, it is your responsibility to obtain the correct referral for those services. It is your responsibility to know your insurance.

Although we will file your insurance forms, payment for your medical services is your responsibility. We will assist you in any way we can to help make this process as smooth as possible. We offer as a courtesy verification of your insurance benefits, however; this is only a quote given by your insurance company. Information may vary from the verification obtained to the actual processing of your clam. It is your responsibility to know your plan benefits.

I acknowledge financial responsibility for services rendered by Charlotte Orthopaedic Clinic, P.A.I understand that I am responsible for prompt payment of any portion of the charges including deductibles, co-pays and co-insurance. My signature authorizes COC to file claims for me and assigns all medical rights and benefits due for these services.

Signed _____ Date _____

Printed Signature _____

Charlotte Orthopaedic Clinic, P.A.

New Patient History **Date_____**

Name: _____ I Prefer to be called: _____
Last First MI Suffix (Jr., Sr., II)

Address: _____City:_____State:_____Zip_____

Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Northern Address: _____City:_____State:_____Zip_____

Age: _____ Date of Birth: _____ Social Security Number: _____ E-mail:_____

Spouse/ Guardian Name:_____ Family Doctor: _____ Phone: _____

Medication Allergies: □ NONE

☐ Penicillin ☐ Sulfa ☐ Morphine ☐ Codeine ☐ Aspirin ☐ Tylenol
☐ Latex ☐ Betadine ☐ Other: _____

Current Orthopaedic Problem (s)

What are you seeing the doctor for today: _____

Is this a second opinion ☐ yes ☐ no Are you right or left handed: ☐ right ☐ left

What caused the pain/injury: ☐ car accident ☐ work accident ☐ injury (other) ☐ no injury

How did the injury occur? _____

When did the injury/accident occur? _____

Duration of symptoms: ☐ days ☐ weeks ☐ months ☐ years

Does the pain radiate to: ☐ shoulder ☐ elbow ☐ fingers ☐ groin ☐ buttock ☐ thigh ☐ foot

The pain is getting: ☐ better ☐ worse ☐ unchanged

The pain is: ☐ constant ☐ occasional

Pain level: ☐ intolerable ☐ tolerable

How would you rate the pain (0=no pain through 10=severe): _____

Does the pain prevent you from doing daily activities? ☐ yes ☐ no

What activities increase your symptoms? _____

Do you use a: ☐ cane ☐ walker ☐ nothing

How many blocks can you walk before stopping? _____

Is the pain improved by: ☐ Aspirin ☐ Tylenol ☐ Advil/Motrin/Ibuprofen ☐ Other: _____

OVER

Charlotte Orthopaedic Clinic, P.A.

List of pain medication taken for this problem: _____

Did medication help? ☐ yes ☐ no

Have you had injections for this problem? ☐ yes ☐ no

What type of injection(s) _____

Did the injection help: ☐ yes ☐ no

Have you had physical therapy? ☐ yes ☐ no If yes, when/ how long/ did it help?_____

Have you had surgery for this problem before? ☐ yes ☐ no If yes, when and where_____

Was surgery successful? ☐ yes ☐ no Complications: _____

Past Medical/Surgical History

Do you have a history of any of the following?

Fracture/broken bone	☐ yes	☐ no	Arthritis	☐ yes	☐ no
Type: _____			Gout	☐ yes	☐ no
Bursitis	☐ yes	☐ no	Tendonitis	☐ yes	☐ no
Bone infection	☐ yes	☐ no	Neck pain	☐ yes	☐ no
Back pain	☐ yes	☐ no	Sciatica	☐ yes	☐ no
Osteoporosis	☐ yes	☐ no			

Do you have any medical conditions (treated or untreated)?

AIDS	☐ yes	☐ no	Anemia	☐ yes	☐ no
Angina	☐ yes	☐ no	Asthma	☐ yes	☐ no
Emphysema/COPD	☐ yes	☐ no	Bladder/Kidney	☐ yes	☐ no
Bleeding disorder	☐ yes	☐ no	Blood clots	☐ yes	☐ no
Cancer Type:_____	☐ yes	☐ no	Diabetes	☐ yes	☐ no
Anxiety	☐ yes	☐ no	Type:_____		
Depression	☐ yes	☐ no	Mental disorder	☐ yes	☐ no
Heart Attack	☐ yes	☐ no	Heart disease	☐ yes	☐ no
Atrial fibrillation	☐ yes	☐ no	High Blood Pressure	☐ yes	☐ no
Pacemaker	☐ yes	☐ no	Parkinson's	☐ yes	☐ no
Alzheimer's	☐ yes	☐ no	Gastric Ulcer	☐ yes	☐ no
Phlebitis	☐ yes	☐ no	Prostate disease	☐ yes	☐ no
Pulmonary emboli	☐ yes	☐ no	Stroke	☐ yes	☐ no
Thyroid disease	☐ yes	☐ no	Liver disease	☐ yes	☐ no
Sleep apnea (on CPAP)	☐ yes	☐ no	Peripheral neuropathy	☐ yes	☐ no
Glaucoma	☐ yes	☐ no	Macular degeneration	☐ yes	☐ no

Other illnesses not listed: _____

_____

Have you had surgery before?

			Right, Left, Bilateral				Right, Left, Bilateral
Tonsillectomy	☐ yes	☐ no		Appendectomy	☐ yes	☐ no	
Hysterectomy	☐ yes	☐ no		Total Hip Replacement	☐ yes	☐ no	_____
Cardiac Stent	☐ yes	☐ no		Total Knee Replacement	☐ yes	☐ no	_____
Vascular surgery	☐ yes	☐ no		Laparoscopy	☐ yes	☐ no	
Shoulder/Rotator cuff	☐ yes	☐ no	_____	Knee arthroscopy	☐ yes	☐ no	_____

Other surgery not listed: _____

_____

_____

Do you currently or within the last 4 weeks have any problems related to the following systems? CIRCLE if yes…

Constitutional:	Fever	Chills	Headache	Other: _____
Eyes:	Blurred vision	Double vision	Eye Pain	Other: _____
Neck:	Neck Pain	Stiffness	Arm Weakness	Other: _____
Neurologic:	Tremors	Dizzy spells	Seizures	Other: _____
Endocrine:	Excessive thirst	Too hot/cold	Fatigue	Other: _____
Gastrointestinal:	Abdominal pain	Nausea/Vomiting	Constipation	Other: _____
Cardiovascular:	Chest Pain	Palpitations	Foot Swelling	Other: _____
Integumentary:	Skin rash	Boils	Persistent itching	Other: _____
Musculoskeletal:	Swollen joints	Painful joints	Neck/Back pain	Other: _____
Ear/Nose/Throat:	Ear infection	Sore throat	Sinus problem	Other: _____
Genitourinary:	Painful urination	Frequent urge	Discharge	Other: _____
Respiratory:	Wheezing	Frequent cough	Short of breath	Other: _____
Hematologic:	Swollen glands	Blood clots	Easy Bruising	Other: _____
Psychologic:	Depression	Anxiety	Difficulty sleeping	Other: _____

Local Pharmacy: Name: _____Phone:_____

List of Current Medications:

If you have a list of your medications you do not need to fill this in, please take it to the receptionist with your finished paperwork and we will be happy to copy it for you.

Name	Dosage (MG)	Frequency	Name	Dosage (MG)	Frequency

Height_____ Weight_____

Family History:

Father: ☐ alive ☐ deceased Age: ___ Cause of death: _____

Mother: ☐ alive ☐ deceased Age: ___ Cause of death: _____

☐ Rheumatoid ☐ Stroke ☐ Cancer Type_____ ☐ Diabetes ☐ Heart disease
☐ Other: _____

Patient Name: _____

OVER

Charlotte Orthopaedic Clinic, P.A.

Social History:

Do you drink alcohol: ☐ no ☐ socially ☐ daily How many drinks per week: _____
Do you smoke: ☐ never ☐ former smoker ☐ current smoker How many per day/how long: _____
Do you use recreational drugs? ☐ never ☐Former ☐ current If yes, what kind/how often:_____

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Ethnicity: ☐ White/Caucasian ☐ Black/African American ☐ Hispanic ☐ Native American ☐ Asian/Pacific Islander
☐ Other: _____ ☐ Prefer not to answer: _____

Level of Education: _____

Employer: _____ Occupation: _____

Hobbies: _____

Do you exercise: ☐ no ☐ yes How often/what type? _____

Sports you participate in: _____

If Student, Name of School_____ City/State_____

Whom may we thank for referring you? _____

Date of last Dental Visit: _____ Dental Problems: _____

I acknowledge that the information provided about my family and medical history is accurate and complete. If there are any changes to this information in the future, I will provide any such change at my next scheduled visit.

_____ _____
Patient or Parent/Guardian Date

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN and TO RELEASE INFORMATION FOR INSURANCE CLAIMS: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible for payment of non-covered services. I hereby authorize the Physician to release any information acquired in the course of my treatment to process insurance claims.

_____ _____
Patient or Parent/Guardian Date