Name:
Chart:
Date: DOB:

ADVANCED ORTHOPAEDICS AND REHABILITATION

PATIENT INFORMATION

PT NAME		SS#	
ADDRESS		BIRTHDAY	MARITAL STATUS
CITY-STATE		SEX	
ZIP		FAMILY PHYSICIAN	
HOME PH		PHYSICIAN PH	
CELL PH		EMERGENCY CONTACT	
WORK PH		EMERGENCY PH	
EMAIL			

RACE	ETHNICITY	LANGUAGE
☐ AMERICAN INDIAN	☐ HISPANIC ORIGIN	☐ DECLINED LANGUAGE
☐ ASIAN	☐ NON - HISPANIC ORIGIN	☐ ENGLISH
☐ BLACK	☐ DECLINED ETHNICITY	☐ FRENCH
☐ NATIVE HAWAIIAN		☐ HINDI
☐ DECLINED RACE		☐ ITALIAN
☐ WHITE		☐ SPANISH
		☐ OTHER

GUARANTOR INFORMATION / PRIMARY INSURANCE HOLDER INFORMATION

GUARANTOR INFORMATION SAME AS ABOVE ☐ (IF CHECKED SKIP TO INSURANCE INFORMATION)

GUARANTOR NAME		BIRTHDAY	
ADDRESS		SEX	
CITY-STATE, ZIP		EMPLOYER	
PHONE #		ADDRESS	
SS#		PHONE	

PATIENT PREFERRED PHARMACY

Complete Pharmacy information below to indicate which pharmacy your electronic prescritpions will be sent.

Preferred Pharmacy Name / Phone Number

Preferred Pharmacy Address / Street City State Zip

PATIENT CONSENT

☐ I agree that Advanced Orthopaedics & Rehabilitation may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

☐ I decline that Advanced Orthopaedics & Rehabilitation may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. This does not prevent Advanced Orthopaedics & Rehabilitation from ePrescribing.

REVISED 09/24/2014

Name:
Chart:
Date: DOB:

ADVANCED ORTHOPAEDICS AND REHABILITATION

ACKNOWLEDGEMENT OF RECEIPT AND CONSENT

I, ____ , give my consent to the practitioners of Advanced Orthopaedics & Rehabilitation to perform medical services determined necessary or advisable for the benefit of my health care. I acknowledge that I have received the Notice of Privacy Practices for Advanced Orthopaedics & Rehabilitation is authorized to use and disclose my protected health information for treatment, payment and health care operations purposes consistent with its Notice of Privacy Practices.

CONSENT TO DISCLOSURE OF PERSONAL HEALTH INFORMATION TO FAMILY MEMBERS

I, ____ , give my permission to the practitioners and staff of Advanced Orthopaedics & rehabilitation to release information regarding my medical care, including my medical condition, test results, appointment dates/times to the following individuals:

Name	Relationship	Telephone Number

Can the staff of this office leave information regarding your care on your voicemail? ☐ Yes ☐ No ☐ Other

FINANCIAL PAYMENT POLICY AND CONSENT

Insurance Reimbursement: The medical services rendered are provided directly to you as our patient and, therefore, you are responsible for payment. If you do not have health insurance coverage, we ask that you make payment at the time of service. If you have active health insurance, we will, as a courtesy, submit a claim to your insurance company for you. Our practice participates with Medicare and many managed care insurance companies. However, due to the increasing number of managed care insurers, it is the sole responsibility of the patient to obtain information from the insurer regarding participation by AOR in the coverage of services rendered. If you are covered by a company with whom AOR participates, we will bill them along the guidelines of our contract with them. However, co-payments, *co-insurances, and deductibles are the responsibility of the patient and payment is expected at the time of service.*
THERE WILL BE A $25.00 NSF FEE ADDED TO ALL RETURNED CHECKS.

Payment Arrangements: If you are not covered by health insurance, your policy does not cover services rendered by AOR or you cannot make full payment due to financial hardship, it will be necessary to set up a payment plan at the time of your visit. If you are in need of special payment arrangements, you must meet with one of our billing staff to make these arrangements prior to leaving the office on the date of your initial visit.

Please Note: All balances over 90 days may be sent to collections
ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance, and any other known plans to Advanced Orthopaedics and Rehabilitation. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. I understand that charges not covered by my insurance, as well as copays and deductibles, are my responsibility and are due at time of service.
I, THE UNDERSIGNED, DO HEREBY AGREE AND GIVE CONSENT FOR AOR TO FURNISH MEDICAL CARE CONSIDERED NECESSARY IN DIAGNOSING AND TREATING MY CONDITION.

I understand and agree to abide by the financial policy of this office.

Patient or Guardian Signature ______________________ Date _________________

Print Name ____ Relationship to Patient _________________

ALL COPAYS, COINSURANCES, DEDUCTIBLES, AND BALANCES DUE AT TIME OF SERVICES. THANK YOU