Name:
Chart:
Date:

Brielle Orthopedics

Name: Today's Date : Social Security# :

Home Phone#: Cell Phone#: How shall we contact you? _____

May we contact you by e-mail? ☐ Yes ☐ No E-mail address: _____

Address: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Language: _____ Race: _____ Ethnicity: _____

Employer: _____ Occupation: _____

Employer Name, Address, Phone _____

Pharmacy Name, Address, Phone _____

Primary Doctor Name, Address, Phone _____

_____

Date of Accident or Illness: _____ Referring physician: _____

For new patients: How did you hear about us? _____

Is this problem related to a Workers Compensation Accident? _____ Motor Vehicle Accident? _____

Please briefly explain the reason for your visit: _____

_____

_____

Where have you had MRIs / X-rays for today's visit? _____ Could you be pregnant? _____

INSURANCE INFORMATION:

Insurance Company Name: _____

Insurance Policy#: _____ Group #: _____

Policyholder Name: _____

Policyholder Birthdate: _____ Policyholder Social Security#: _____

SECONDARY INSURANCE INFORMATION:

Insurance Company Name: _____

Insurance Policy#: _____ Group #: _____

Policyholder Name: _____

Policyholder Birthdate: _____ Policyholder Social Security#: _____

IF THE PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Responsible Party: _____ Relationship: _____

Address: _____

Home Phone#: _____ Cell Phone#: _____ Social Security#: _____

Name:
Chart:
Date:

PAST MEDICAL HISTORY:

Circle one

NO	High Blood Pressure	YES
NO	Diabetes	YES
NO	Gout	YES
NO	Blood Clot	YES
NO	Cancer	YES
NO	Heart Disease	YES
NO	Bleeding Problems	YES
NO	Problems with Anesthesia	YES

HOSPITALIZATIONS/SURGERIES:

_____

_____

_____

_____

MEDICATIONS:

_____

_____

_____

_____

FAMILY HISTORY:

Circle one

NO	High Blood Pressure	YES
NO	Diabetes	YES
NO	Gout	YES
NO	Blood Clot	YES
NO	Cancer	YES
NO	Heart Disease	YES
NO	Bleeding Problems	YES
NO	Problems with Anesthesia	YES

SOCIAL HISTORY:

Number of Children & Ages:

_____

NO	Tobacco Use	YES
	Packs per day: _____	
NO	Alcohol Use	YES
	Drinks ____ Frequency____	
NO	Drug Use	YES

ALLERGIES:

Circle one

None Penicillin Sulfa

OTHER _____

REVIEW OF SYSTEMS:

NO	Constitutional (fever, weight loss, etc.)	YES
NO	Eyes (double vision, blurring, glasses)	YES
NO	ENT & Mouth (deafness, sinusitis, dizziness)	YES
NO	Heart (chest pain, murmur, irregular beats)	YES
NO	Circulation (high blood pressure)	YES
NO	Respiratory (asthma, shortness of breath, cough)	YES
NO	GI (appetite diarrhea, constipation)	YES
NO	Urinary (problem urinating, incontinence)	YES
NO	GYN (menstrual problems, pregnancies)	YES
NO	Musculoskeletal (arthritis, stiffness)	YES
NO	Skin (acne, rash)	YES
NO	Breast (lump)	YES
NO	Neurological (seizures, weakness, balance)	YES
NO	Psychiatric (depression, mood liability, other)	YES
NO	Endocrine (thyroid problems)	YES
NO	Hematologic (bleeding tendency, anemia)	YES
NO	Lymphatic (enlarged lymph nodes)	YES
NO	Allergy (hay fever, dermatitis)	YES

OTHER: _____

_____

_____

Your height: _____ Your weight: _____

Patient Signature: _____

Date: _____

Physicians Signature: _____

Date: _____

Name:
Chart:
Date:

NOTICE OF PRIVACY PRACTICES

We are legally required to protect the privacy of your health information. This includes information that can be used to identify you, and that we have created or received about your past, present or future health condition, the provision of the health care to you, or the payment of this health care. We are legally required to follow the privacy practices that are described in this notice. We reserve the right to change the terms of this notice and our privacy policies at any time.

Disclosures of your health information without your authorization:
We may disclose your health information to hospitals, physicians, nurses and other health professionals in order to provide, coordinate or manage your health care. For example, we may provide this information to a pharmacy to fill prescriptions or to a laboratory to order a blood test. We may use and disclose your health information in order to bill and collect payment for the treatment and services provided to you. This includes providing your health information to another health care provider involved in your care for the other provider's payment activities. We may disclose your health information, as necessary, to operate this facility and provide quality care. For example, we may use your health information in order to evaluate the quality of the health care service provided to you. We may disclose your health information when such disclosure is required by federal, state or local law or when subpoenaed or ordered in a judicial or administrative proceeding. We may disclose your health information for public health activities. For example, to report information concerning various diseases, product defects, public health surveillance activities, investigations and interventions as permitted or required by law, or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease. We may disclose your health information for health oversight activities, government or other health oversight agencies, as authorized by law. We may disclose your health information to funeral directors and for the purpose of organ donation. We may disclose your health information, in certain circumstances, in order to conduct medical research. We may disclose your health information in order to avoid a serious threat to your health or safety, to the health or safety of another person, or to the public. We may disclose your health information in order to comply with workers' compensation laws. We may disclose your health information to provide appointment reminders, information about treatment alternatives or information about other health care services or benefits we offer.

Uses and Disclosures Where You Have the Opportunity to Object:
We may provide your health information to a family member, friend or other person that you indicate is involved in your health care, or the payment of your health care unless you object in whole or part. Other than as stated above, we will not disclose your health information without your written authorization. You can later revoke your authorization in writing except to the extent that we have already taken action in reliance upon the authorization. An incidental use or disclosure may occur, as in the case where a disclosure about a patient's health information may be overheard by persons not involved in that patient's care. Such an incidental use or disclosure is a secondary use or disclosure that cannot be reasonably prevented, and occurs as a by-product of an otherwise permitted use or disclosure.

You Have the Following Rights With Respect to Your Health Information:
You have the right to request in writing that we limit how we use and disclose your health information. You may not limit the uses and disclosures required by law. We will consider your request, but we are not legally required to accept it. If we do accept your request, we will put any limits in writing. You have the right to request that we send information to you at an alternate address. We must agree to your request so long as we can easily provide it in the manner you requested.

In most cases, you have the right to look at or get copies of your health information that we have, but you must make the request in writing. We will respond to your request within 30 days. In certain situations, we may deny your request. If we deny your request, we will tell you in writing the reasons for our denial. You have the right to have such a denial reviewed. If you request a copy of our information, we may charge you a reasonable fee for the costs of copying, mailing or other costs incurred by us in complying with your request. You may agree to a summary of your information, if you agree to the cost involved, in advance.

Name:
Chart:
Date:

You have the right to a list of disclosures we may have made other than those for purposes of treatment, payment or normal health care operations, or those made directly to yourself or your family. Such a list will also not include disclosures made for national security purposes, to corrections or law enforcement personnel, or prior to April 1, 2003. We will respond within 60 days of your request. We will provide one listing during any twelve-month period without charge. Subsequent lists will be subject to a reasonable cost-based fee. You have the right to correct or update your health information. If you believe there is an error in your health information that we have, you may request in writing, that we correct the error or add missing information. We will respond within 60 days of receiving your request. We may deny your request, and our written response will state the reason for our denial. You have a right to file a written statement of disagreement with our denial. If you think that we have violated your privacy rights, or if you disagree with a decision we have made about your access to your health information, you may file a complaint with the Secretary of Health and Human Services. Please contact Kathy Moss, Manager, (732) 840-7500, for information.

Name:
Chart:
Date:

Patient Financial Policy

Thank you for choosing **Brielle Orthopedics**! We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship.

We sincerely hope that by sharing our financial expectations we will strengthen the physician-patient relationship and keep the lines of communication open. This financial policy helps us provide quality care to our valued patients. If you have any questions or need clarification of any of the below policies, please feel free to contact our billing department at 855-240-0451 (or Kathy Moss, Administrator at 732.840.7500).

Payment is Due At the Time of Service

- As part of your relationship with Brielle Orthopedics, payment for services rendered is your responsibility. The terms of this financial policy may be amended by the practice without prior notification to the patient.
- We accept cash, checks, debit, and credit card (no American Express).
- All co-payments, deductibles, co-insurance and fees for non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment.
- Insurance required co-payments are due when you check in for your appointment. If you arrive without your co-payment, we may ask you to reschedule. We charge an administration fee of $25 for co-payments not paid at the time of check in.
- Patient-responsible balances are due when you check in for your appointment, unless prior arrangements have been made with the billing department. Past due accounts are to be paid in full before future appointments are made.
- In the event you need surgery we will provide you an estimate of your insurance required deductible and co-insurance amounts.
- We request that at least **24 hour** advance notice be given to the office if you will be unable to keep your EMG scheduled appointment. We charge an administration fee of $50 for no-shows. Patients who repeatedly "no show" for appointments may be discharged from the practice.

Proof of Insurance

- Please bring your insurance card(s) and a valid photo ID with you to each appointment.
- It is your responsibility to notify the Practice of changes in your health insurance, address and phone number.
- Brielle Orthopedics participates in the Federal Medicare program.
- We will submit claims to all payors for services rendered to you.

Self-Pay Accounts and Charity

- We designate accounts, **Self-Pay**, under the following circumstances: (1) patient does not have health insurance coverage (2) patient is covered by an insurance plan that our providers do not participate in, (3) patient does not have a current, valid insurance card on file, (4) patient does not have a valid insurance referral on file or (5) patient declines to provide a social security number.

Name:
Chart:
Date:

- Self-Pay patients, please be prepared to pay a minimum of $200 on the date of service. There may additional fees for X-Ray and DME or other supplies or services. If you are unable to pay, please ask to speak to the billing department to make payment arrangements.

- Charity Care patients will be responsible to provide the office with the appropriate referral and card prior to the office visit or will be considered Self Pay.

Referrals

If you have an HMO plan we are contracted with, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, call your primary care physician to obtain it. Without an insurance required referral, the insurance company will deny payment for services. As such, if you are unable to obtain the referral at that time, you will be rescheduled or asked to pay for the visit in advance.

Our Responsibility to Report Non-Compliance

It is our obligation under many of the insurance contracts to report patients who: repeatedly refuse to pay co-payments/deductibles at time of service, or who repeatedly "no show" for scheduled appointments.

Divorce and Child Custody Cases

- The parent or guardian who brings the child to the office for care is responsible for payment at the time of service no matter if the account is self-pay, participating insurance, or nonparticipating insurance. The Practice does not honor divorce specifics (*e.g., percentage of financial responsibility).*

- If the child has coverage with a participating insurance plan and the proper insurance identification is present at the time of service, the Practice will bill that insurance company. Applicable co-payments, coinsurance and/or deductibles are due at the time of service, unless arrangements have been made with the office prior to arrival.

- In cases of divorce, the individual who receives care is responsible for payment of co-payments, coinsurance, deductibles, and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.

Billing, Payments and Refunds

- If we must send you a statement, the balance is due in full within 14 days of the statement date.
- If you cannot pay the balance in full with 14 days, please contact our billing department to see if you qualify for special payment options.
- It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.
- We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this Practice.
- There will be a charge for the following:
  Medical Records $1 per page
  Copies of Images $10 per disc
  No Charge for the Primary Disability Form, any additional forms will be $10 per form

Name:
Chart:
Date:

DME

- All durable medical equipment given in the office cannot be returned.
- The item will be billed to your insurance carrier and any balances will be the responsibility of the patients.
- All patients will be offered the opportunity to allow Brielle Orthopedics to dispense the necessary DME and will be given a list of optional suppliers if the patient so chooses to obtain independently.
- A separate waiver will be required for all Medicare patients and private insurance companies based on individual contracts.

1. I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.
2. I authorize my insurance benefits be paid directly to **Brielle Orthopedics**
3. In order to properly treat me, I authorize **Brielle Orthopedics** permission to view my prescription medication records.
4. I authorize **Brielle Orthopedics**, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.
5. I authorize **Brielle Orthopedics** to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.
6. I authorize **Brielle Orthopedics** to contact or discuss my personal health information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

X Patient/ Guarantor Signature: _____ Date: _____

Acknowledgement of Sample Practice Notice of Privacy Practices

I hereby acknowledge that I have reviewed or received or have been given the opportunity to receive a copy of **Sample Practice** Notice of Privacy Practices.

X Patient/ Guarantor Signature: _____ Date: _____