



Financial Policy

Thank you for choosing us as your orthopaedic specialists. We are committed to providing you the best possible care & are pleased to discuss our professional fees with you at any time. The following is a statement of our Financial Policy which we require you to read and sign prior to any medical services.

- FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE.
- ALL PAYMENTS WILL BE COLLECTED UPON CHECKING IN FOR YOUR SCHEDULED APPOINTMENT.
- WE ACCEPT CASH, PERSONAL CHECKS, VISA, AND MASTERCARD.

INSURANCE

- **If we are a participating provider with your insurance plan you are responsible for all co-payments deductibles and any non-covered services at the time of service.** As a courtesy we will file insurance claims with most insurance carriers, provided you have supplied us with the proper information.
- If we are NOT a participating provider with your insurance plan you are responsible for full payment at time of service. If you need to file your own insurance our office will provide you with the proper documentation.
- Bills for surgery will not include charges of anesthesia, hospitalization, or laboratory test. These are billed separately, from the facility where the surgery is performed.

MINOR PATIENTS

The adult parent or guardian accompanying the minor is responsible for payment of the minor patient's account regardless of who the insurance policy holder is. For unaccompanied minors non-emergency treatment can be denied until a parent or guardian is present or we have written permission for treatment and payment of the account period.

WORKMAN'S COMPENSATION

All workmen's compensation claims must be verified in writing by the employer. Verbal or telephone verifications are not acceptable. If you have seen another physician for the same complaint an authorization for a change of physician must be verified on your company's form.

PERSONAL INJURY WITH ATTORNEY

If you are being represented by an attorney or a third party payer, we will provide you with the proper information to file your claim. You are responsible for full payment to our office at the time services are rendered.

AUTOMOBILE ACCIDENT

If you were in an automobile accident and you have "Med-Pay" automobile insurance our office will provide you with the proper documentation to file the claims. It will be your responsibility to file the claims. If you have health insurance we will file a claim for all professional services received.

FORMS:

We will be happy to complete any medical forms. Payment of \$20.00 is required prior to completion of each form(s). Please allow 7-10 business days for your form to be completed. We will notify you when the form is ready.

MISSED APPOINTMENTS

Failure to give 24 hour notice of cancellation of your appointment will result in a \$25.00 fee billed directly to you. We will not bill your insurance company for this amount. You will be responsible for prompt payment of this fee prior to being seen at your next scheduled visit.

COLLECTIONS

If your account balance becomes past due and is sent to an outside collection agency, you will be responsible for any additional fees incurred.

All monthly statements are due and payable in full upon receipt.

All returned checks are subject to a \$25.00 service fee.

If you need to make special payment arrangements this needs to be brought to our attention prior to being examined. Your signature below indicates that I understand and agree to this financial policy.

Signature of Patient or Guardian

Date



- CONSENT TO LEAVE MEDICAL INFO WITH SOMEONE OTHER THAN THE PATIENT

I am authorizing the personnel at Wake Orthopaedics, LLC to leave information related to my medical care with others if I am not available. Check all that apply:

_____ I authorize that information can be left with my wife/husband/significant other.

Name of person:_____.

_____ I authorize that information can be left on my answering machine (phone #): _____.

_____ I authorize that information can be left on my voice mail (phone #): _____.

_____ Other: I authorize that information can be left:

I understand that this authorization will be valid until I give written notification otherwise.

- RECEIPT OF NOTICE OF PRIVACY PRACTICES: WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Wake Orthopaedics, LLC Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my protected health information (PHI).

Signature of Patient

Date

Relationship to Patient (if signed by a personal representative of patient:

Patient Personal Representative

Date

Witness

Date

Wake Orthopaedics
PATIENT INFORMATION FORM

First Name	Middle Initial	Last Name		
Street Address		City	State	Zip Code
County	Email Address			
Home Phone ()	Work Phone ()	Date of Birth	Age	Social Security #
Marital Status	Gender Male Female	Employer/School Name & Address		
Family Physician		Referring Physician/Referral Source		
Person to Contact in Case of Emergency		Relationship	Phone Number ()	
Spouse/Parent Name		Social Security #	Phone Number ()	
Spouse/Parent Address		City	State	Zip Code
Problem Information				
Injured/ Painful Area: _____ () Right () Left Date of Injury/Onset: _____				
Medication Allergies: No () Yes () If "Yes" List Allergies _____				
Was this a motor vehicle accident? Yes No		If yes, provide name of Insurance Company		
Was this a work-related injury? Yes No		Employer at time of injury		
Please Complete Insurance Information				
Insurance Company		Policy Number		
Subscriber's Name		Subscribers Social Security # & DOB		
Subscriber's Employer				
Secondary Insurance Company		Policy Number		
Subscriber's Name		Subscribers Social Security # & DOB		

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT TO PAY PROVIDER DIRECTLY:

I authorize the release of information to my referring or family physician and/or that which is necessary to file claims to the insurance carrier and the billing of my account for payment. I understand that you may be transmitting any records electronically, and I absolve all parties of any liability relating to such transmission of said records. I authorize my insurance carrier to make payment directly to Wake Orthopaedics, LLC. I understand that I am responsible for any remaining balance due on my account not covered by my insurance carrier. Thus, if the account balance is not satisfied within 30 days after the first notification, the account may be referred for legal action. I consent to the treatment rendered to me under the general/special care of the attending physician.

Signature _____ **Date** _____



HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed & how you can access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

Please contact David Pontz for Questions or Complaints

Wake Orthopaedics

3009 New Bern Ave

Raleigh, NC 27610

919-232-5020

This notice was published and becomes effective on/or before July 14, 2008. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Wake Orthopaedics, LLC

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____, have received a copy of Wake Orthopaedics, LLC Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my protected health information (PHI).

Signature of Patient

Date

Patient Chart #

Relationship to Patient (if signed by a personal representative of patient:

Patient Personal Representative

Date

Witness

Date

Wake Orthopaedics, LLC

Patient Medical History

Date: _____

Chart # _____

Patient: _____

Wake Ortho Physician: _____

Primary Care Physician: _____

Referring Physician: _____

Please share with your healthcare provider, the activities you are most eager to resume following treatment:

I. Past Medical History: Please list any of the following that apply:

Injuries: _____

Operations (i.e. tonsillectomy): _____

Illnesses (i.e. diabetes): _____

Current Medications & Purpose: _____

Drug Allergies: _____

Please list any previous fractures: _____

Please list the date of your last Bone Density Test: _____

II. Social History:

Occupation: _____

Tobacco? YES NO Packs/day _____

Alcohol? YES NO Amount _____

Daily Activities (prior to injury): Independent _____ Require Assistance _____

Walking (prior to injury): Normal _____ Cane/Walker _____ Wheelchair _____

III. Family History: Does anyone in your immediate family (mother, father, siblings, children) suffer from any of the following? (Please identify which family member)

Heart Disease: _____

Cancer (type): _____

Diabetes: _____

Lung Disease: _____

Stroke: _____

Tuberculosis: _____

Alzheimer's: _____

Scoliosis: _____

Parkinson's: _____

Arthritis: _____

Seizures: _____

Multiple Sclerosis: _____

Rheumatoid/osteoarthritis: _____

IV. Please indicate if you have ever sought medical treatment for any of the following symptoms.

	YES	NO		YES	NO		YES	NO
Weight Loss	_____	_____	Vision	_____	_____	High Blood Pressure	_____	_____
Fever, chills	_____	_____	Hearing	_____	_____	Leg swelling	_____	_____
Appetite change	_____	_____	Skin rash/ bed sores	_____	_____	Low Blood Pressure	_____	_____
Joint Pain	_____	_____	Pneumonia	_____	_____	Chest pain	_____	_____
Muscle Pain	_____	_____	Fatigue	_____	_____	Fainting spells	_____	_____
Gout	_____	_____	Nausea	_____	_____	Shortness of breath	_____	_____
Headaches	_____	_____	Vomiting	_____	_____	Asthma	_____	_____
Redness/swelling of a joint	_____	_____	Diarrhea	_____	_____	Cough	_____	_____
Frequent falls	_____	_____	HIV	_____	_____	Memory loss	_____	_____
Seizures	_____	_____	Frequent urination	_____	_____	Heart Murmur	_____	_____
Stroke	_____	_____	Shingles	_____	_____	Kidney stones	_____	_____
Numbness	_____	_____	Anxiety	_____	_____	Anemia	_____	_____
Kidney Disease	_____	_____	TB	_____	_____	Blood clots	_____	_____
Hepatitis	_____	_____	Depression	_____	_____	Seasonal Allergies	_____	_____
Diabetes	_____	_____				Hallucinations	_____	_____
						Thyroid Disease	_____	_____

Patient/Guarantor Signature: _____

Date: _____

All items on this page were reviewed by _____ (MD/PA initials) on _____ (date).