Today's Date: _____

Atlantic Orthopaedics, P.A.

Patient Information

Please complete each line and print clearly. Please complete front and back of form.

Last name First name Middle initial Social Security #

Local Address (Street, City, State, & Zip Code) Home Phone Number

Permanent Address (Street, City, State, & Zip Code) Cell Phone Number

E-Mail Address Emergency Contact Name & Phone Number

Date Of Birth_____ Male / Female Marital Status _____

Employment_____

Referring Physician Name (Full name): _____

Primary Care Physician (Full name): _____ Phone Number:_____

Responsible Party- Information for policyholder if different then above:

Last name First name Middle initial Home Phone Number

Birth Date Employer

Primary Insurance_____ Policy Number/ID#_____
Group Number_____ Group Name_____
Subscriber's Name_____ Subscriber's SS#_____
Subscriber's DOB: _____ Relationship to Patient_____
*NOTE: If the patient is a child and is covered under both parents' insurance, please indicate whose birthday (mother/father) is closest to January_____

Secondary Insurance:_____ Policy Number/ID#_____
Group Number_____ Group Name_____
Subscriber's Name_____ Subscriber's SS#_____
Subscriber's DOB _____ Relationship to Patient_____

Is this a **WORK** or **AUTO** related injury? (Circle one) Date of Injury_____
Employer: Body Part Injured:
Claim Number_____ Contact Person_____ Telephone #_____
Insurance Company and Address to send claims:_____
Did you file an accident report? To Whom?
How did the accident occur?

Over

PATIENT AGREEMENT FOR FINANCIAL RESPONSIBILITY

I, _____, understand that the physician's billing staff will file all claims for services rendered to my insurance carrier, if applicable. I also understand that if I am not insured, I must pay my balance for services rendered by my provider. I acknowledge that I am responsible for any balances that may be due to the physician because of: Co-insurance or co-pay amounts, yearly deductible amounts, non-covered services, out of Network charges, terminated coverage, exhausted auto benefits, denied Worker's Compensation claim, no insurance coverage, no referral obtained from Primary Physician, failure to respond to insurance carrier correspondence, and failure to respond to coordination of benefits inquiry.

I understand that I will receive a statement for any balance due, after my carrier has processed the claim. I understand and I agree that the balance of my statement will be paid in full to the physician within 30 days. If I am unable to pay the entire amount (applies to amounts of $150.00 or more), I am responsible to immediately, upon receipt of statement, call the billing office @ 484-705-0793, to arrange a monthly payment plan, for no less than $50.00 per month.

I understand that failure to pay my balance or arrange payments and follow that payment agreement may result in **Collection Agency** action and that I will be responsible for any charges incurred due to the collection process.

_____ _____

Name of Patient (Print) Patient's Date Of Birth

_____ _____

Signature of patient/guardian/responsible party Date (mm/dd/yy)

HIPAA

Revisions, we will provide you with a revised notice on your next visit. The revised policies and practices will apply to all protected health information that we maintain.

Requested to inspect information: As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access by asking our receptionist or contacting the medical records department in writing.

Complaints: if you would like to submit a comment or complaint about our privacy practices, or suspect violation, you can do so by letter, outlining your concerns. Please address this correspondence to the privacy officer, 314 Franklin Avenue Suite 105B, Berlin MD 21811.

Consent to use and disclose protected information.

Your protected health information will be used by this practice, known as Atlantic Orthopaedics, P.A. or disclosed to you for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent.

You may request a restriction on the use or disclosure of your protected health information. If you should wish to restrict your disclosure, you should make the request in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restriction will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke this consent to use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy prices outlined in the notice.

Please list individuals (including relationship) with whom you authorize to have access to your personal health information:

Full Name	Relationship	Contact Number

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to his practice to use and disclose my health information in accordance with it.

_____ _____

Name of Patient (Print) Date Of Birth

_____ _____

Signature of Patient Date

_____ _____

Signature of Patient Representative Relationship to patient

Authorization for Release of Information and Assignment of Benefits

I _____ (Print legal full name) Hereby authorize and direct my insurance benefits to be paid directly to my personal physician or his/her group practice.

I also authorize my physician or group practice to release any information necessary to process this claim. I understand that the follow information will be released to:

- Billing department of the physician and/ or practice
- Insurance carrier to process claim

I understand that my information under certain circumstances may be released for one of the following reasons:

- Other healthcare professionals in order to coordinate my care or treatment
- Insurance adjuster- If my claim is a work or motor vehicle injury
- Employer- If my claim is related to work injury
- Attorney- If my claim is in litigation process
- Health insurance carrier for chart audit reason, not for claim payment
- I understand that my physician and/ or his/her staff and the billing office will not release any information to me or family member over the phone without verification of my identity in order to comply with privacy regulations. I also understand that my physician and his/her staff and the billing office will maintain the utmost respect for privacy. However, I also understand that there are physical constraints such as noise and the ability to overhear information and other errors that may occur that may cause inadvertent dissemination of information, as well as potential confidential information to be disclosed after it has been provided to outside sources such as your insurance carrier from the clinical or billing office.

  This office is not responsible for any disclosure or our confidential medical information once we provide this information **at your request**, to your insurer, employer, family member or otherwise.

  With this full understanding, I indemnify and hold harmless this practice for any disclosure, which is out of my physician's, his/her staff and or billing office control.

  By my signature I state that I have read, understand and agree to this authorization and release

_____	_____	_____
Patient Signature	Date Signed	Social Security Number

_____	_____	_____
Parent or Guardian Signature	Print Name	Date Signed