

TODAY'S DATE: ____/____/____ DATE OF INJURY: ____/____/____

IS THIS INJURY WORK RELATED? Yes No

IS THIS INJURY THE RESULT OF AN MOTOR VEHICLE ACCIDENT? Yes No

PATIENT INFORMATION

PATIENT'S NAME (Last, First, Middle Initial) _____

RESPONSIBLE PARTY (If under 18) _____

HOME ADDRESS _____ APT # _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (____) _____ WORK PHONE (____) _____

CELL PHONE (____) _____ EMAIL _____@_____

DATE OF BIRTH ____/____/____ AGE _____ SEX: Male Female SOCIAL SECURITY # _____ - _____ - _____

EMPLOYER _____ OCCUPATION _____ FULL-TIME STUDENT Yes No

EMPLOYER'S ADDRESS _____ APT # _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT _____ PHONE (____) _____

PRIMARY CARE PHYSICIAN _____ PHONE (____) _____

REFERRING PHYSICIAN _____ PHONE (____) _____

FOR MEDICARE PATIENTS ONLY: Do you currently reside in a Skilled Nursing Facility? Yes No

INSURANCE AND BILLING INFORMATION

PRIMARY INSURANCE COMPANY _____

Address _____ City _____ State _____ Zip _____

Policy # _____ Group # _____ Effective Date _____

Policy Holder's Name _____ Date of Birth _____ Relation to Patient _____

Policy Holder's Employer _____ Employer's Address _____

Relationship to Patient Self Spouse Child Parent Other _____ SOCIAL SECURITY # _____ - _____ - _____

SECONDARY INSURANCE COMPANY _____

Address _____ City _____ State _____ Zip _____

Policy # _____ Group # _____ Effective Date _____

Policy Holder's Name _____ Date of Birth _____ Relation to Patient _____

Policy Holder's Employer _____ Employer's Address _____

Relationship to Patient Self Spouse Child Parent Other _____ SOCIAL SECURITY # _____ - _____ - _____

SEND BILL TO _____ Relationship to Patient _____

ADDRESS _____ APT # _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (____) _____ WORK PHONE (____) _____

CELL PHONE (____) _____ EMAIL _____@_____

WORK-RELATED INJURY

DATE OF INJURY: ____/____/____ WAS INJURY REPORTED TO SUPERVISOR? Yes No

NAME OF EMPLOYER and SUPERVISOR _____ PHONE (____) _____

INSURANCE CARRIER and MAILING ADDRESS: CLAIM # _____ ADJUSTER _____

PHONE (____) _____

FAX (____) _____

PATIENT AUTHORIZATION

I hereby authorize COUNTRYSIDE ORTHOPAEDICS, PC (CSO) to apply for benefits on my behalf for covered services rendered by CSO and that payment be made directly to CSO for said services.

I certify that the information I have reported above, including the cause of my injury, if applicable, and my insurance coverage, is correct. I further authorize the release of any necessary information, medical and other, required to facilitate any claim to determine benefits to which I may be entitled. I will be responsible for any balance deemed patient responsibility by my insurance carrier, including my co-payment, co-insurance, deductible, non-covered and non-payable charges. Payment is expected in full upon receipt of statement or payment arrangements must be made with our Billing Office.

I will be responsible for the balance of charges not covered by my health or workman's compensation insurance and agree to promptly pay for services rendered to me or the patient above. If I fail to meet my financial commitment to CSO and it becomes necessary to take action to collect my account, I agree to pay any and all costs, expenses and fees related to the collection thereof and agree that the jurisdiction for said collection shall be Loudoun County, Virginia. I further agree to pay for any missed appointment of which I did not notify the medical office at least 24-hours prior to the scheduled appointment.

I permit a photocopy of this authorization to be used in place of the original.

In accordance with Virginia law, we may destroy patient charts six (6) years after the last documented record; in the case of a minor, records must be retained until the patient reaches the age of 18.

The undersigned has read, understands, acknowledges and agrees with the above terms and conditions.

Signature of Subscriber or Beneficiary

Date

COUNTRYSIDE ORTHOPAEDICS, PC

Due to the increasing demands on our staff we have found it necessary to implement the following policies:

- (1) Payment is due at the time services are rendered even if a statement has not been sent reflecting the amounts due. This includes co-pay, co-insurance, deductible and non-covered services considered patient responsibility. We accept cash, personal checks, debit cards, Discover, MasterCard, Visa and American Express.
- (2) Patients who do not arrive for their appointment prepared to pay their copay will be rescheduled.
- (3) Statements indicating patient responsibility are due upon receipt. An assessment of \$10 will be reflected on your next statement if payment is not received.
- (4) If payment is not received after you have been sent three (3) statements you will receive a courtesy call as a reminder to submit your payment after which your account will be processed by our collection agency.
- (5) Please update your address, telephone numbers, current insurance card(s) and driver's license when you check-in for your appointment
- (6) For all patients arriving late for their appointment time: the receptionist will check with the doctor or physician's assistant who will determine if you can be seen. Those patients arriving more than 15 minutes late may need to be rescheduled.
- (7) For all patients with insurance requiring a REFERRAL or CONSULTANT TREATMENT PLAN, **you must present your referral to the receptionist at check-in time**, otherwise, you will be required to reschedule your appointment. Our contracts with these insurance carriers mandate that we cannot see patients without their Referral or Consultant Treatment Plan at the time services are rendered. Please check with the receptionist when you check out to make sure that your referral will still be valid for your next appointment.
- (8) According to OSHA regulations, durable medical equipment, soft goods and orthopedic devices provided by this office are neither returnable nor refundable.
- (9) Prescriptions for narcotics must be picked up and signed for during business hours; we will not mail these prescriptions.
- (10) Non-narcotic prescriptions can be picked up at this office. We require 72-hours advance notice to have your prescription ready. If you request that we mail your prescription there will be a \$5.00 fee, payable in advance by credit card. Please try to remember to request refills at the time of your appointment or have your pharmacist fax the request to this office at (703) 858-1801. Please note that we can only fax prescription refills to local pharmacies and not mail-order pharmacies.
- (11) If you request a copy of a prescription for physical therapy, labs, CT Scan, Bone Scan or MRI we require 72 hours advance notice to have the copy available for you to pick-up. If you request that we mail these documents to you there will be a \$5.00 fee, payable in advance by credit card. If you request a copy be made available for pick-up on the same date you call there will be a \$10.00 fee payable in advance by credit card. Due to HIPAA regulations, labs and other reports cannot be faxed.
- (12) In order for this office to obtain the pre-authorization necessary for you to schedule your procedure (i.e., CT Scan, Bone Scan, MRI, etc.) you must provide us with the location where the procedure will be conducted. Once we have obtained pre-authorization, any change to the location where the procedure will be conducted will result in a \$10 fee, payable in advance by credit card, to obtain pre-authorization for a different location.
- (13) If you request copies of your records you will need to sign a release of record form and there will be a \$10.00 handling fee plus \$0.50 per page and \$7.00 per x-ray film. These fees will be payable in advance by credit card. Your copies will be available within fifteen (15) business days.
- (14) For disability and other forms that need to be completed, there will be a \$25.00-\$50.00 fee depending upon the complexity of the paperwork. This amount will apply each time the form is completed and will be payable in advance by credit card.
- (15) The returned check fee is \$25.00.

We appreciate and thank you for your cooperation.

Patient Signature _____

Date _____