ACTION ORTHOPAEDICS AND SPORTS MEDICINE

PATIENT DEMOGRAPHICS

Patient Information				
Last Name	First Name	Middle Name	Suffix	Social Security #

Gender (Please Circle) M / F	Date of Birth	Marital Status (Please Circle) Single Married Divorced Widowed Other

Preferred Language (Please Circle) English Spanish Other _____	Race (Please Circle) Asian Black/African American White Other_____	Ethnicity (Please Circle) Hispanic Not Hispanic Unknown

Address	City	State	Zip Code
Home Phone	Cell Phone	Work Phone	
Email Address			

Responsible Party Check if same as Patient ( )			
Last Name	First Name	Gender (Please Circle) M / F	
Address	City	State	Zip Code
Home Phone	Cell Phone	Work Phone	
Responsible Party Social Security #	Relationship to Patient		

Emergency Contact Check if same as Responsible Party ( )			
Last Name	First Name	Gender (Please Circle) M / F	
Address	City	State	Zip Code
Home Phone	Cell Phone	Work Phone	
Email Address	Relationship to Patient		

Insurance Information Check if Self Pay ( )			
Check if same as Responsible Party ( )		Check if same as Responsible Party ( )	
Subscriber / Member Name		Subscriber / Member Name	
Gender (Please Circle M / F	Date of Birth	Gender (Please Circle) M / F	Date of Birth
Primary Insurance Company		Secondary Insurance Company	
Insurance Mailing Address		Insurance Mailing Address	
City/State	Zip Code	City/State	Zip Code

ACTION ORTHOPAEDICS AND SPORTS MEDICINE

Subscriber/Member #	Subscriber/Member #
Group Number	Group Number

PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____

COMMUNICATION BY PHONE

HOME PHONE: (_____) _____ CELL PHONE: (_____) _____ WORK PHONE: (_____) _____

☐ OKAY TO LEAVE MESSAGE WITH DETAILED INFORMATION

☐ OKAY TO LEAVE MESSAGE WITH DETAILED INFORMATION

☐ OKAY TO LEAVE MESSAGE WITH DETAILED INFORMATION

☐ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

☐ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

☐ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

WRITTEN COMMUNICATION

OKAY TO MAIL TO MY HOME ADDRESS: _____

OKAY TO SEND TO MY EMAIL ADDRESS: _____ OKAY TO FAX TO NUMBER PROVIDED: _____

ADDITIONAL AUTHORIZED POINTS OF CONTACT

I HEREBY GIVE PERMISSION TO ORTHOPEDIC SPECIALISTS OF NORTH TEXAS TO DISCLOSE AND DISCUSS ANY INFORMATION RELATED TO MY MEDICAL CONDITION(S) TO/WITH THE FOLLOWING PEOPLE(S):

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

☐ I DO NOT WISH TO GIVE PERMISSION FOR MY HEALTH INFORMATION TO BE DISCLOSED AND DISCUSSED WITH ANY OTHER PEOPLE.

THE DURATION OF THIS AUTHORIZATION IS INDEFINITE UNLESS OTHERWISE REVOKED IN WRITING. I UNDERSTAND THAT REQUESTS FOR MEDICAL INFORMATION FROM PERSONS NOT LISTED ABOVE WILL REQUIRE A SPECIFIC AUTHORIZATION PRIOR TO THE DISCLOSURE OF ANY MEDICAL INFORMATION.

ACTION ORTHOPAEDICS AND SPORTS MEDICINE

PATIENT SIGNATURE: _____ **DATE**: _____

FINANCIAL POLICY, ASSIGNMENT, AND RELEASE OF INFORMATION

It is FMA's policy to inform every patient of our payment procedures. Please read and mark the section below that is applicable to you.

___ 1. **PATIENT WITH INSURANCE**

You are responsible for deductibles, copayments, non-covered services or equipment, co-insurance and items considered 'not medically necessary' by your insurance company. Plan/Insurance co-pays and deductibles/co-insurance payments are required at the time services are rendered. If you or your insurance carrier make payments exceeding your balance, reimbursements will be remitted. If payment cannot be made at your time of service, a payment arrangement will need to be put in place.

___ 2. **Patient without insurance/Self-pay patient**

If you do not have insurance coverage, FMA expects complete payment at each time of service. There will be a required deposit of $200 due upon arrival for your appointment. Any charges that exceed that $200 will be collected at check out. If your final balance falls under the $200, refunds will be given at check out.

___ 3. **MEDICARE PATIENT**

Our office will submit your Medicare charges to Medicare and your secondary/supplemental insurance, but you are still responsible for all deductibles, co-payments, and non-covered services.

___ 4. **WORKER'S COMPENSATION PATIENT**

As a worker's compensation patient, you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury did occur during employment, so we can best suit your needs. Any balance discrepancies will still fall under the responsibility of the patient.

___ 5. **PERSONAL INJURY (MOTOR VEHICLE ACCIDENT, ETC.) PATIENT**

If you are a person injury (moto vehicle, etc.) patient, our office policy states that payment is due at the time of service as we do not participate in third-party billing. You are responsible to pay for each visit in full.

___ 6. **REFUNDS**

To receive a payment refund, the following criteria must be met:

- There must be no outstanding insurance claims on the account
- There must be no outstanding balance(s) on the patient account

If such criteria can not be met, a refund will not be issued. If the refund denial reason is due to an outstanding balance that is owed to the clinic, the refund amount will be applied to that balance.

ACTION ORTHOPAEDICS AND SPORTS MEDICINE

RELEASE OF INFORMATION

I HAVE READ AND AGREE TO THE FINANCIAL POLICY OF THIS MEDICAL PRACTICE AND AUTHORIZE FMA TO RELEASE TO MY INSURANCE CARRIER(S) FOR ANY INFORMATION NEEDED TO DETERMINE BENEFITS OR BENEFITS PAYABLE FOR RELATED SERVICES.

Signature of Patient: _____ **Date:** _____

NOTICES OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCES TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Original Effective Date: April 14, 2003

Last Revised Date: November 30, 2017

The Health Insurance Portability & Accountability Act of 1196 ("HIPPA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how personal health information ("PHI") is used. HIPPA provided for covered entities that misuses personal health information.

As required by HIPPA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may create and distribute de-identifiable health information (with shared Electronic Health Records) by removing all references to individually identifiable information.

We may use and disclose your medical records only for each of the following purposes, treatments, payments and, health care operations.

- Treatments mean providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a different specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing, or collections activities and utilizations review. An example of this would be including sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, public health and safety issues, health research, state and federal law compliance, organ and tissue donation requests with medical examiner or funeral director, worker's compensation, law enforcement, government requests, and lawsuit/legal actions.

ACTION ORTHOPAEDICS AND SPORTS MEDICINE

The following use and disclosures of PHI (Patient Health Information) will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of Psychotherapy notes
- Uses and disclosure of your PHI (Protected Health Information) for marketing purposes, including subsidized treatment and health care operations
- Disclosure that constitutes a sale of PHI (Patient Health Information) under HIPPA
- Other uses and disclosures not described in this notice

You may revoke such authorizations in writing and we are required to honor and abide by that written request; except to the extent that we have already taken actions relying on your authorization.

NOTICE OF PRIVACY PRACTICES CONTINUED

You may have the following rights with respect to you PHI (Protected Health Information)

- The right to request restrictions on certain uses and disclosure of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to honor a restrictions request except to limited circumstances which we shall explain if you ask. IF we do agree to the restrictions, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information.
- The right to inspect and copy your PHI
- The right to have your PHI amended
- The right to receive an accounting of disclosures of our PHI
- The right to obtain a paper copy of the notices
- The right to be activated if your unprotested PHI is intentionally or unintentionally disclosed
- The right to be advised if your unprotected PHI intentionally or unintentionally disclosed.

If you have paid for services “out of pocket”, in full request that we do not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

This notice is effective as of November 30, 2017e and it is our intention to abide by the terms of those Notice of Privacy Practices and HIPPA Regulations currently in effect. We reserve the right to change the terms of

ACTION ORTHOPAEDICS AND SPORTS MEDICINE

Notice of Privacy Practices and to make the new notice provision effective for all PHI that we maintain. You may file a formal complaint to the US Department of Health and Human Services for Civil Rights:
200 Independence Avenue, SW
Washington, DC 20201
1-877-696-6775
Or visiting the website at WWW.HHS.GOV/OCR/PRIVACY/HIPPA/COMPANTS
You may contact our Practice Compliance Officer at the following address and phone number:

Practice Compliance Officer:	Terri Dickerson
Address:	220 N. Ridgeway Dr.
	Cleburne, Texas 76033
Phone Number:	817-774-5005
Email Address:	tdickerson@cleburnefma.com

I ACKNOWLEDGE THAT I WAS PROVIDED WITH THE NOTICE OF PRIVACY PRACTICES OF THE MEDICAL PRACTICE NAMED AT THE TOP OF THIS PAGE.

Signature of Patient: _____ **Date:** _____