WELCOME TO NORTHERN ROCKIES ORTHOPAEDICS, PLLP

Date: _____

PATIENT INFORMATION

Is an attorney involved in your case? ☐ Yes ☐ No If so, who: _____

If Medicaid, Passport Provider name _____

Previous / Maiden Names _____

RESPONSIBLE PARTY FOR SERVICE PROVIDED

Last Name _____ First _____ Middle _____

Address _____ City _____ ST _____ Zip _____

Home Phone # (____) _____ Other # (____) _____ , Age _____

Date of Birth ____ / ____ / ____ Social Security # _____

Marital Status: _____ Married _____ Single _____ Widow(er) _____ Divorced _____ Separated _____

Employer _____ Employer's Phone # _____

Employer's Address _____ City _____ ST _____ Zip _____

Name of Spouse: _____ Date of Birth ____ / ____ / ____

Spouse Social Security: _____

Spouse Employer: _____ Employer Phone: _____

Whom May We Thank For Your Referral? _____

AUTHORIZATIONS:

I understand that as part of my healthcare, this practice originates and maintains health records & radiology films describing my health history, symptoms, examination and test results, diagnosis, treatment and plans for future care and treatment. The health records & radiology films will be retained by Northern Rockies Orthopaedics, PLLP even if my healthcare provider(s) leave the practice.

Signature of Patient / Legal Guardian: _____ Date: _____ Update: _____

I authorize the release of any medical information necessary to process insurance claims and request payment of benefits either to myself or the party who accepts assignment / participates.

Signature of Patient / Legal Guardian: _____ Date: _____ Update: _____

As the party responsible for medical decision making for the child represented in this medical record, I hereby give my consent to Northern Rockies Orthopaedics, PLLP to render both emergency and non-emergency healthcare services both in and out of my physical presence.

Signature of Patient / Legal Guardian: _____ Date: _____ Update: _____

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Northern Rockies Orthopaedics, PLLP for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Northern Rockies Orthopaedics, PLLP. I understand that diagnosis or treatment of me by _____M.D. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Northern Rockies Orthopaedics, PLLP is not required to agree to the restrictions that I may request. However, if Northern Rockies Orthopaedics, PLLP agrees to a restriction that I request, the restriction is binding on Northern Rockies Orthopaedics, PLLP and _____M.D.

I have the right to revoke this consent, in writing at any time, except to the extent that Northern Rockies Orthopaedics, PLLP or _____M.D. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Northern Rockies Orthopaedics, PLLPs' Notice of Privacy Practices prior to signing this document. Northern Rockies Orthopaedic, PLLPs' Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Northern Rockies Orthopaedics, PLLP. The Notice of Privacy Practices for Northern Rockies Orthopaedics, PLLP is also provided in the office waiting room. This notice of Privacy Practices also describes my rights and Northern Rockies Orthopaedics, PLLPs' duties with respect to my protected health information.

Northern Rockies Orthopaedics, PLLP reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____ _____
Name of Patient or Personal Representative Date

COLLECTION/PAYMENT POLICY

It is the policy of Northern Rockies Orthopaedics, PLLP to have a Financial Policy that clearly outlines patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care and minimizing administrative costs. This Financial Policy has been established with these objectives in mind, and to avoid any misunderstanding or disagreement concerning payment for professional services.

- Our office participates with numerous insurance companies and managed health care programs. For patients that are members of one of these plans, our business office will submit a claim for services rendered. The patient must complete all necessary insurance information, including special forms, before leaving the office.
- If a patient has insurance that we do not participate in, our office is happy to file the claim upon request; **however, payment in full is expected at the time of service.**
- It is the patient's responsibility to pay any deductible, co-insurance, co-payment, or any portion of the charges as specified by the plan at the time of visit. Any medical services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of visit.
- **Payment for professional services can be made with cash, check, MasterCard, Visa or American Express.**
- If a patient feels that he or she may require financial assistance, notify the practice receptionist before you see the physician, for referral to the appropriate individual. Patients that do not have insurance are expected to pay for professional services at time of service unless prior arrangements have been made with us.
- I understand that in the event any unpaid balance is placed for collections with any third party collection agency, an attorney fee will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, and all other expenses so stated elsewhere. The authorized attorney fees and the additional costs and charges listed above represent the actual costs incurred by NRO to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signers failure to pay as specified in this agreement.
- It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice **before the visit.** Visits may be rescheduled, or the patient may be financially responsible due to lack of the referral.
- It is the patient's responsibility to provide us with current insurance information and to bring their insurance card to each visit.
- Our staff is happy to help with insurance questions relating to how a claim was filed, or regarding any additional information the carrier might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company's member services department (number is on the insurance card).
- The adult accompanying a minor, (18 years and younger), and the parents (or guardians of the minor) are responsible for payment at the time of service. For unaccompanied minors, non-payment at time of service needs to be authorized **prior** to the visit.
- I understand that I will be charged a $25 fee on all appointments not cancelled within 24 hours of visit.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the physician's office. We are here to help you. **Please sign that you have read and agree to this Financial Policy.**

_____ _____
Signature of Patient/Responsible Party **Date**