NEW PATIENT INTAKE FORM

BASIC INFORMATION

Date:_____

First Name:_____ Last Name:_____ MI:____

Sex:_____ DOB:_____ Marital Status:_____ Email:_____

Patient SS#:_____ Preferred Language (circle one) : English Spanish Other: _____

Address:_____ City:_____ State:_____ Zip:_____

Main Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Cell: (_____) _____-_____

Spouse's Name:_____ Spouse: Main Phone: (____)____-_____ Other:(____)____-_____

Occupation:_____ Employer Name:_____ Work Status:_____

Employer Address:_____ City:_____ State:_____ Zip:_____

Emergency Contact: _____ Relationship: _____ Phone: (____) _____-_____

Ethnicity/Race (optional): _____

Allergies: _____

How Did You Hear About Us? (Choose all that apply)

☐ Referring Physician: Name: _____
☐ Emergency Department/Urgent Care
☐ Google Ad or Internet Ad
☐ Newspaper
☐ Friend or Family
☐ Other _____

Is this a Workman Comp Injury? ☐ Yes ☐ No

Is this Related to an Auto Accident? ☐ Yes ☐ No

PRIMARY INSURANCE INFORMATION

Insurance Name:_____ Policy Holder Name:_____

Relationship:_____ Policy Holder SS#:_____ Policy Holder DOB:_____

Sex:_____ Address:_____ Contact Phone: (_____)_____-_____

SECONDARY INSURANCE INFORMATION

Insurance Name:_____ Policy Holder Name:_____

Relationship:_____ Policy Holder SS#:_____ Policy Holder DOB:_____

Sex:_____ Address:_____ Contact Phone: (_____)_____-_____

Name (Please Print) _____ Date of Birth: _____

HIPAA RELEASE OF INFORMATION

As required by the privacy regulations created as a result of HIPAA, North Point Orthopaedics is dedicated and committed to your health information. In conducting business, North Point Orthopaedics will comply with all legal duties and responsibilities that apply with HIPAA. I have been offered a copy of the HIPAA privacy practice and policy. I have previously read the office policy. I understand that I am responsible for all charges not paid by my insurance company. Should it be necessary for North Point Orthopaedics to submit my account to a collection agency or attorney, I understand I will be responsible for any costs of collection services, including reasonable attorney fees. I understand that this authorization shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, for this date forward until revoked in writing.

H.H.S. Pursuant to Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of Notice of Privacy Practices.

Signature: _____ **Date:** _____

Signature of Responsible Party: _____ **Relationship:** _____

AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

Authorization for Treatment: I hereby authorize the physician to conduct such examinations, perform such procedures as are medically required, and administer treatment and medication as deemed necessary or advisable. I hereby certify that I have read and fully understand this authorization form. I also certify that no guarantee has been made as to the results that may be obtained.

Release of Information/Medical Records Diagnosis: I hereby authorize the physician(s) providing service and any other authorized person to release to its authorized billing agents, any physician who treated me, my insurance carrier, employer's workmen's compensation insurance, or any other category/third party payor, the Social Security Administration under Title IVII (18) of the Social Security Act, the Professional Review Organization, or other intermediaries responsible for payment of my charges, a complete report of services rendered including diagnosis, findings, details of treatment, and progress for the purpose of receiving payment for the services rendered. I understand that I may revoke this consent at any time by giving a written notice. I understand that if I refuse to consent to the release of information, I will be held responsible for payment of all charges for services rendered. I give permission to North Point Orthopaedics and all clinical providers who have provided care for me, along with any billing service, collection agencies, attorney or other agents who may work on their behalf, to contact me on my cell phone and/or home phone using automatic dialing systems or other computer assisted technology.

Authorization for Assignment of Benefits/Financial Obligation: In consideration of medical services provided, I hereby assign and transfer to the physician all of my rights, title and interest to medical reimbursement, including, but not limited to, the right to designate a beneficiary, add dependent eligibility and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by my physician, including medicare part B. I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance. I understand that if I do not pay the balance in full, my account will be placed for collection and I will be responsible for all collection expenses including reasonable attorney's fees and court costs. It is our policy to charge a fee for any check that is returned due to insufficient funds.

Co-Payments: I understand that if my medical insurance requires a co-pay or encounter fee, the payment is due <u>at the time of service.</u>

Precertification: If my insurance requires precertification, it is my responsibility to make sure it is obtained. I will be held financially responsible if the precertification is not obtained.

Signature: _____ **Date:** _____

Signature of Responsible Party: _____ **Relationship:** _____

Name (Please Print) _____ **Date of Birth:** _____

MEDICAL AND BILLING INFORMATION

Do you give our medical or billing staff permission to discuss your medical/billing information including laboratory findings with family members or other care providers?

☐ **NO**
☐ **YES**

If You Answered Yes To The Above, Please provide name(s) and phone number(s) below)

Name:_____ **Relationship:**_____ **Phone:** (_____)_____-_____

Name:_____ **Relationship:**_____ **Phone:** (_____)_____-_____

Name:_____ **Relationship:**_____ **Phone:** (_____)_____-_____

Messages Related to My Care Can Be Left On: (Check all that apply)

☐ **None – All messages to be relayed directly**
☐ **Voicemail:** (_____)_____-_____
☐ **Text Messages:** (_____)_____-_____

Signature: _____ **Date:** _____

Signature of Responsible Party: _____ **Relationship:** _____

APPOINTMENT CANCELLATION - NO SHOW - LATE ARRIVAL POLICY

North Point Orthopaedics, LLC goal is to provide quality individualized medical care in a timely manner. "No Shows" and late cancellations inconvenience those individuals who are in need of medical treatment. We would like to remind you of our office policy regarding missed appointments. North Point Orthopaedics, LLC, understand that delays may occur, however, we strive to see patients at their scheduled time. Patients arriving 30 minutes after their scheduled appointment time may be asked to reschedule. This will be evaluated on a case by case basis per the physician discretion.

Failure to give 24 hour advance cancellation or being a "No Show" will result in a nonrefundable administrative charge of $40.00. This fee will not be covered by your insurance company. If you have any questions regarding this policy, please ask our staff and we will be glad to clarify your questions. We thank you in advance for your cooperation and understanding.

**** I acknowledge that I understand the Appointment Cancellation - No Show – Late Arrival Policy ****

Signature: _____ **Date:** _____

Signature of Responsible Party: _____ **Relationship:** _____

Thank You for Choosing North Point Orthopaedics