Fayetteville Orthopaedics & SPORTS MEDICINE
Physical & Occupational Therapy

PATIENT INFORMATION SHEET

Patient's Name (Last, First, MI)			Mailing Address		
City		State	Zip	Home Phone / Cell Phone	
Patient's Employer			Occupation		Work Phone
Sex M☐ F☐	Marital Status Sgl☐ Mar☐ Div☐ Wid☐ Oth☐		Patient's Birthdate MM_____DD_____YYYY_____	Age	Preferred Language
Patient SSN		Referring Provider?		Who is your Primary Care Provider?	
Person to notify in Emergency			Relationship		Phone #
Responsible Party Name for Billing (*if minor*)		DOB	Responsible Party SSN		Relationship to Patient Parent☐ Other☐
Primary Insurance Policyholder's Name		DOB	Sex M☐ F☐	Employer	Phone #
Insurance Company	Policy #		Group #		Patient's Relationship to Policyholder Self☐ Spouse☐ Child☐
Secondary Insurance Policyholder's Name		DOB	Sex M☐ F☐	Employer	Phone #
Insurance Company	Policy #		Group #		Patient's Relationship to Policyholder Self☐ Spouse☐ Child☐
Additional Insurance Policyholder's Name		DOB	Sex M☐ F☐	Employer	Phone #
Insurance Company	Policy #		Group #		Patient's Relationship to Policyholder Self☐ Spouse☐ Child☐

MEDICARE Patients: Nursing/Rehab Facility: Yes☐ No☐ Facility Name: _____

Facility Address: _____ Phone #: _____

MEDICARE INFORMATION
STATEMENT TO PERMIT MEDICARE PAYMENT TO PROVIDER

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or it's intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

DATE: _____ **SIGNATURE:** _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize payment of the surgical and/or Medical Benefits, if any, otherwise payable to me, directly to the Physician for his services as described. I realize that I am responsible for payment for non-covered services. I also authorize the Physician to release any information acquired in the course of my treatment that is necessary to process insurance claims.

DATE: _____ **SIGNATURE:** _____

I agree that Fayetteville Orthopaedics & Sports Medicine may contact me by telephone, electronic messages, mail or cell phone as provided by me or person on my behalf or that are identified as mine at a later date. I understand that these communications may be from this medical provider and/ or those providing services within the facilities of, or on behalf of, this medical provider including communications about the scheduling, treatment or payment for services rendered. These calls include but are not limited to using an automatic telephone dialing system, artificial or prerecorded voice or calls to a telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service, or other radio common carrier service ("Authorized Communications"). I understand that my agreement to the terms of the Patient Consent and Assignment of Insurance Benefits is not a condition of willingness to provide treatment to me. I consent to any and all of the authorized communication methods even if I will incur a fee or a cost to receive such communications. I agree that the consent and authorizations I have provided herein may be revoked only in writing addressed to the relevant entity's Practice Administrator.

DATE: _____ **SIGNATURE:** _____

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION TO FAMILY[1]

I have received a copy of the Fayetteville Orthopaedics & Sports Medicine's Notice of Privacy Practices.
I grant permission for Fayetteville Orthopaedics to send me email reminders, notices and other information.

Email Address:_____

Print Name:_____

Signature:_____

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment for my care:

a. _____ Relationship_____ Phone_____

b. _____ Relationship_____ Phone_____

Check all that may apply:

- ☐ All my medical information
- ☐ Information necessary to schedule appointments for me
- ☐ Lab or test results
- ☐ Information necessary to provide, call in or pick up prescriptions for me
- ☐ Information necessary to help my family member(s) take care of me
- ☐ Information necessary to allow my family member(s) to pick up or arrange for medical equipment to be provided for me
- ☐ Information necessary to bill for or submit claims for care provided to me to government or private insurance payors

My consent will remain in effect as long as I am a patient of Fayetteville Orthopaedics & Sports Medicine unless and until I notify Fayetteville Orthopaedics in writing of any changes.

_____ _____
Signature of Patient or Parent / Legal Gaurdian Date

_____
Print Name of Patient / Legal Gaurdian

[1] Although allowed under HIPAA, North Carolina law does not permit release of PHI outside of the Hospital unless required by law, pursuant to a court order or patient authorization, or for treatment, payment, or health care operations purposes as defined and limited by HIPAA. There is no exception for family members except for residents of a nursing home. The North Carolina physician-patient privilege statute, N.C.G.S. § 8-53, and HIPAA allow verbal authorization or consent for release, respectively, of information to family members. However, the better practice is to document the patient's consent in order to have clear evidence of the patient's intent. The package does not include a consent or authorization to release PHI to other providers or to insurance companies or others since most providers already have such forms. The contents of this form can be combined with such existing consent forms.

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PATIENT FINANCIAL POLICY

As a service to our patients, we will file insurance claims for each of your insurance policies. We do not file third party payors i.e. auto accident insurance, personal injury liability, etc. We accept assignment of benefits from your insurance company, but **patients are required to fulfill co-pay, co-insurance, and deductible obligations at the time you receive services.**

Our financial services goal is to assist patients through individual attention and constructed mutual agreements between both parties for personal balance payments. We offer an extensive list of payment options:

- *Cash or personalized check*
- *Partnering with CareCredit, healthcare financing*
- *Major credit cards, i.e. Visa and MasterCard*
- *Interest based preference*
- *Monthly payment plan centered on outstanding balance*

If our *on-call* physician attended to you in the emergency room and a follow-up visit at our practice is required, we will see you for your first appointment, with or without payment, but you will receive a bill for services. Any visit thereafter will require a payment at the time services are rendered

Self-pay patients are required to pay a deposit of $212.00 prior to being seen at our practice.

Our billing staff is available to discuss and assist payment options.

Monthly payment plan minimums:

- *Balance < $500:* *$50 per month*
- *Balance $500-$750:* *$75 per month*
- *Balance $751-$1,200:* *$100 per month*
- *Balance >$1,200:* *$150 per month*

_____
Print Name of Patient or Parent/Legal Guardian

_____ _____
Signature of Patient or Parent/Legal Guardian Date

POLICY ACKNOWLEDGMENT FORM

PRESCRIPTION POLICY

By signing below, I agree that I have read and understand this clinic's policy regarding the prescription of medications:

1. **Refills will take 2-3 business days to process**. Our providers are not in clinic everyday due to their surgery schedules
2. **You must call the Prescription Refill Line in order to request a refill of your medication**. Refill requests will not be done on a walk-in basis. Narcotics are not refilled through the Prescription Refill Line, unless surgery was done in the last 90 days and with provider approval. If we have prescribed a narcotic to treat your pain, you have signed a "Narcotics Policy," therefore agreeing to our terms.
3. Depending on the medication and your medical conditions, a follow-up visit may be needed in order safely refill your medication

PATIENT FINANCIAL POLICY

By signing below, I agree that I have read and understand this clinic's financial policy and acknowledge the immediate need to notify Fayetteville Orthopaedics & Sports Medicine of any changes to my physical home, mailing address, phone number and adjustments regarding my insurance information and understand the Patient Financial Policy.

PATIENT PHOTO POLICY

By signing below, I agree to have my photo taken in order to match my Electronic Medical Record (EHR) to my demographics. I understand that this photo will only be used for identification purposes, at each subsequent visit and will not be shared with any outside sources.

IDENTIFICATION CARD SCANNING/PHOTOCOPYING POLICY

By signing below, I understand that my identification card will be scanned in order to be attached to my personal Electronic Medical Record (EHR) for identification and billing purposes only. My identification will not be shared with any outside sources, unless it's for billing/insurance claims purposes.

Patient or Parent of Patient / Legal Guardian

PRINT NAME: _____SIGNATURE: _____

Date: _____ Relationship to Patient: _____