UNIVERSITY HIP & KNEE
ORTHOPAEDIC SPECIALISTS LLC

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Patient Information Form

General Information

Today's date _____/_____/_____

Patient's name _____
Last name First name Middle initial

Address _____
Street City State Zip code

Home # (_____) _____ Cell # (_____) _____ Work # (_____) _____

Preferred telephone contact Home _____ Cell _____ Work _____

Date of Birth _____/_____/_____ Sex M ___ F ___ Marital status _____
mo day year S, M, D, W

Living situation: lives alone _____ w/ spouse _____ w/ children _____ assisted living _____ other _____

Social Security # _____ _____ _____ Email address _____

Driver's License # _____ State _____ Occupation _____

How were you referred to our practice? For example: physician, another patient, hospital, insurance comp, marketing, etc

_____
Name Address Phone number

Primary physician _____
Name Address Phone number

Employer _____ ___
Name Address Phone number

Do you have a living will (advanced directive) Yes ___ No ___ If yes, who has a copy? _____

Do you have a health care proxy? Yes ___ No ___ If yes, who is your health care proxy? _____

Emergency Contact Name _____ Relationship to patient _____

Emergency Contact address _____

Emergency Contact phone _____ _____
Home Cell

Alternate Emergency Contact (at different address) _____ Relationship to patient _____

Emergency Contact address _____

Emergency Contact phone _____ _____
Home Cell

Responsible Party Information **IF SAME AS PATIENT, CHECK HERE ____, LEAVE THIS SECTION BLANK AND CONTINUE ON TO INSURANCE INFORMATION SECTION**

Responsible Party Name _____
Last First Middle initial

Address _____
Street City State Zip code

Phone _____ _____
Home Cell

Date of Birth _____/_____/_____ Age _____ Marital Status _____ Sex M___ F ___
mo day year

Social Security # ____/____/_____ Relationship to patient _____ Occupation _____

Employer _____
Name Address Phone number

Insurance Information

Check all that apply; please have insurance card(s) available for our receptionist to copy/ scan.

☐ **Primary Health Insurance:**

Insurance Carrier _____

Policy Holder's Name _____ Relationship to Policy Holder _____

Policy Holder's date of birth _____/_____/_____ Policy Holder's Social Security # _____/_____/_____

Policy Holder's Employer_____

Policy # _____ Group# _____ Co-pay _____

What is your deductible? $_____ How much of your deductible have you satisfied? $_____

☐ **Secondary or Other Health Insurance:**

Insurance Carrier _____

Insurance Carrier's Address and phone _____

Policy Holder's Name _____ Relationship to Policy Holder _____

Policy Holder's date of birth _____/_____/_____ Policy Holder's Social Security # _____/_____/_____

Policy Holder's Employer_____

Policy # _____ Group# _____ Co-pay _____

What is your deductible? $_____ How much of your deductible have you satisfied? $_____

☐ **Worker's Compensation/ Motor Vehicle Insurance:**

Insurance Carrier _____ Adjuster _____
Name Address Phone Number

Policy/ Case/ Claim # _____ If applicable: Date of Accident ____/____/____ Place of Accident: _____

Is this visit authorized? _____ By whom? _____ Authorization # _____

Patient Agreement

In order to establish and maintain a physician-patient relationship with our practice, the following terms must be acknowledged by the patient or responsible party. Please read, initial or sign and date where appropriate.

Authorization for release of information

I authorize University Hip and Knee Orthopaedic Specialists LLC to release medical information that may be required

- To determine whether medical services provided will be covered and paid by my insurance carrier(s) or other guarantors.
- To obtain any necessary pre-authorization or pre-certification for medical services.
- To provide for any diagnostic or therapeutic recommendations including, but not limited to, medications, physical therapy, home care services, laboratory testing, radiological studies, medical consultations.

Signature: _____ Date: ____/____/_____

Professional Fees

I understand that I am financially responsible for all charges for professional services, whether or not paid by an insurance carrier or health plan. Exceptions are when patient financial responsibility is limited by statutory regulation (such as Medicare fee schedule, Motor Vehicle fee schedule, an authorized Workers compensation claim) or by managed care (PPO, HMO, etc) contracts.

In the instances in which the physician is to be paid by my insurance carrier, I

a. understand that it is my responsibility to pay, in a timely manner, any deductible, co-payment, and "non-covered" service as allowed by my plan (Note: Not all services are a covered benefit in all contracts. If you are not sure if a particular service is covered, you should verify this with your insurance company.)
b. request that payment of authorized medical benefits be made on my behalf and assigned to University Hip and Knee Orthopaedic Specialists LLC/ Donald R. Polakoff, MD.
c. understand that in the event my insurance carrier issues payment directly to me, it is my responsibility to forward that payment along with the explanation of benefits for appropriate posting of the payment to University Hip and Knee Orthopaedic Specialists LLC.

Signature: _____ Date: ____/____/_____

Managed Care

In order for any Managed Care agreement/ fee schedule to be applicable and valid,

a. the patient must provide proof of coverage (valid insurance card) at the time of service
b. any required written authorization/referral must be provided at the time of service
c. any managed care co-pay is due at the time of each office visit

Initials: _____ Date: ____/____/_____

Forms, Reports and Copies of Medical Records

Requests for completion of forms, reports, copies of medical records or other paperwork may require a fee, paid in advance, related to amount of preparation involved. Completion of forms, unrelated to providing essential medical care, may be denied in cases where there is an outstanding balance.

Initials: _____ Date: ____/____/_____

Worker's Compensation/ No-Fault Accidents

SKIP TO NEXT SECTION ONLY IF YOU WILL NOT BE FILING A WORKER'S COMPENSATION OR MOTOR VEHICLE CLAIM

It is the patient's responsibility to clearly identify those medical injuries/conditions, which he/she believes are due to a motor vehicle accident, or are work related at the time of the initial visit.

Workers' Compensation Claims:
In order for this office to submit a claim for medical services to be covered by Workers' Compensation, we must receive written (letter or fax) authorization from the employer or its Workers' Compensation Insurance Carrier prior to the initial office visit. The patient is responsible for any charges for professional services, which are denied due to lack of proper authorization.

Motor Vehicle (PIP) Claims:
Insurance claims resulting from Motor Vehicle accidents must be submitted to your Motor Vehicle (PIP) carrier and cannot be billed to the patient's private insurance unless PIP coverage has been denied, does not exist, or private insurance was selected as the primary carrier. The patient is responsible for any deductibles or copayments under their PIP coverage. I agree to have a lien placed against any settlement I receive due to this accident to pay any open balances due to University Hip and Knee Orthopaedic Specialists LLC.

Initials: _____ Date: ____/____/_____

Medical- Legal Reports/Testimony

I understand that by entering into a doctor-patient relationship at University Hip and Knee Orthopaedic Specialists LLC our obligation is to provide you with accurate copies of your medical record. Upon proper written authorization and pre-paid copying, clerical, and postage fees, copies of medical records will be provided. I understand that narrative reports, independent medical evaluations, depositions, and court appearances can interfere with my physician's obligation to his other patients, and therefore will be done only at the physician's discretion. Fees for such services are payable in advance, and must be scheduled in a manner that does not compromise others patients' care.

Initials: _____ Date: ____/____/_____

Cost of Collection

If this account becomes delinquent, I may be responsible for additional billing costs paid to the attorney or collection agency. Also, I have been advised that there is a 1.5% per month finance fee for accounts that are delinquent. I acknowledge a fee of $30 or the actual bank charge, whichever is greater, for any returned check.

Statement of Understanding

I have completed these forms and certify that I am the patient or duly authorized agent of the patient authorized to furnish this information requested. A photocopy of this form shall be considered as valid as the original.

_____ _____/_____/_____
Signature of Patient (or responsible party) Date

_____
Printed name of Patient (or responsible party)

Authorization for Assignment of Benefits

Please accept this Assignment of Benefits as a blanket Assignment of Benefits for charges on services rendered and submitted by University Hip and Knee Orthopaedic Specialists LLC on my behalf. I, the undersigned, authorize and request that

_____

Please print your insurance carrier's name here

for such services as listed above, change the assignee and make payment for benefits which may be due herein to:

University Hip and Knee Orthopaedic Specialists LLC Tax ID: 14-2011247

_____ _____/_____/_____

Signature of Policy Holder Date

_____ _____

Identification Number Group Number

_____ _____

Patient's Name Relationship to Policy Holder