NEW PATIENT REGISTRATION FORM

Who Referred You To Our Office?: _____

Who Is Your Primary Care Physician?: _____

PATIENT DEMOGRAPHIC INFORMATION

Patient Social Security Number: _____

First Name: _____ Middle: _____ Home Address: _____

Last Name:_____ City: _____ State: _____ Zip: _____

Male Female Date of Birth: _____/_____/_____ Home Phone: (_____)_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Cell Phone: (_____)_____

Employment Status: ☐ Employed ☐ Retired ☐ Student Work Phone: (_____)_____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Is This Visit For A... ☐ Car Accident ☐ Work Injury

Cardholder's Name:_____ Relationship To Patient: _____

Policy #: _____ Group #: _____

Contact Number: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Contact Number: _____

Cardholder's Name:_____ Relationship To Patient: _____

Policy #: _____ Group #: _____

GUARANTOR / RESPONSIBLE PARTY INFORMATION

☐ Check If Patient Is Guarantor *(If Checked, You Do Not Need To Fill Out This Section)*

Guarantor Name:_____ Relationship To Patient: _____

☐ Male ☐ Female Date of Birth: _____/_____/_____ Guarantor Social Security #: _____

Home Address: _____ Home Phone: (_____)_____

City: _____ State: _____ Zip: _____ Emergency Contact: (_____)_____

PATIENT FINANCIAL AGREEMENT

Understanding our financial policies is an important part of your overall experience with our office and staff. Feel free to ask any questions you may have about this financial agreement. Please read these policies carefully and sign below, indicating that you have read and understand the policies detailed within.

INSURANCE PARTICIPATION

We are participating providers for both Medicare and Aetna. We do accept all insurance coverage and payments from all insurance carriers including coverage related to motor vehicle accidents and worker's compensation type injuries. Our office does not accept Medicaid or HMO-type policies from private insurance carriers other than Aetna.

OUR RESPONSIBILITY TO YOU:

1. To keep up-to-date records of your insurance coverage.

2. To submit medical claims to your insurance carrier on your behalf and to make appropriate appeals when claims are initially denied by your insurance carrier.

3. To help you understand the specific details of your insurance coverage and to define any out-of-pocket expenses you may incur from receiving your care from our office.

YOUR RESPONSIBILITY TO OUR OFFICE:

1. To provide accurate and up-to-date insurance information to our office. Failure to provide us with this information may lead to denial of claims and cause you to be personally responsible for charges incurred.

2. To be responsible for any out-of-pocket expenses that are owed as dictated by your insurance coverage. Depending on your insurance coverage this **may** include any of the following types of payments:

   a. "***Co-Payment***": a payment that may be required at the time of an office visit as a mechanism by which you share the cost of that visit with your insurance carrier. This is usually a flat fee paid per visit, regardless of the total amount of charges incurred.
   b. "***Co-Insurance***": a payment that shares some of the overall cost of your care with your insurance carrier. This is usually determined after the charges have been processed by the insurance carrier and an "Explanation of Benefits" or "E.O.B." has been issued. A plan will have a set ratio, for example 70/30, where the insurance carrier pays 70% of the allowed amount and you are responsible for 30%.
   c. "***Deductibles***": these are amounts that are paid out by the patient before any payments are made by the insurance carrier. A $500 deductible means that the patient is responsible for paying the first $500 of the charges incurred. Once the deductible is "met" then your insurance carrier will begin covering their portion of the allowed charges. Deductibles can be per individual or per family. Deductibles usually reset every January 1st.

I have read and agree to the polices listed above. I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described. I realize that I am required to pay for non-covered services.

_____ _____

Signature Date

MICHAEL BETSY, M.D.
ORTHOPAEDIC SURGERY & SPORTS MEDICINE, L.L.C.

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Signature of Patient or Legal Representative Witness

_____
Signature

_____
Date

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