PEDIATRIC PATIENT REGISTRATION FORM

Today's Date: _____ *Clinic Name:* _____

PATIENT INFORMATION: (Please use full legal name, no nicknames please)

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Address: _____ **SS#** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: (_____) _____ **Cell Phone: (_____)** _____

Date of Birth: _____ **Age:** _____ **Sex: Female [ ] Male [ ]**

Emergency Contact Name: _____ **Emerg Phone #: (_____)** _____-_____

PARENT INFORMATION: (List person or Insured name responsible for bill – use full legal name, no nicknames please)

****Person responsible for Bill:** _____**Mother** _____**Father** _____**Other** _____

Other person who can give consent if parents cannot be reached (*MUST BE A RELATIVE*), please provide name and relationship:

_____

****Mom's First & Last Name:** _____**DOB:** _____ **SS#:**_____

Mother's Maiden Name: _____**Mother's Work Phone #**_____

****Dad's First & Last Name:** _____**DOB:** _____ **SS#:**_____

Married _____ **Divorced:** _____ **Single:** _____ **Mom's Cell:** _____

Home Phone #: (_____)_____-_____ **Dad's Cell:** _____**Dad's Work Phone #**_____

Address (if different from above) _____

_____

Please provide name of patients siblings: _____

_____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

PRIMARY INSURANCE:

****Policy Holder's name :** _____ **Insurance Name:** _____

****Policy Holder's Social Security #:** _____ ****Policy Holder's DOB:** _____

****Policy / ID #:** _____ **Group #:** _____ **Eff Date:** _____

Insurance Claims Address & Phone: _____

_____

SECONDARY INSURANCE:

****Policy Holder's name :** _____ **Insurance Name:** _____

****Policy Holder's Social Security #:** _____ ****Policy Holder's DOB:** _____

****Policy / ID #:** _____ **Group #:** _____ **Eff Date:** _____

Insurance Claims Address & Phone: _____

**** Required Fields Please attach a copy of patient's insurance card in addition to completing all information on this form.**

_____

Please read and sign back of form.

MEDICALEDGE HEALTHCARE GROUP
PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: _____ **Date of Birth:** _____
First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to MedicalEdge Healthcare Group or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that MedicalEdge is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to MedicalEdge Healthcare Group or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the MedicalEdge Healthcare Group Patient Information Privacy Policy. I hereby authorize MedicalEdge Healthcare Group or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a MedicalEdge Healthcare Group representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying MedicalEdge Healthcare Group to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my MedicalEdge physician or his or her designee.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____
(If different from patient)

GUARANTOR NAME (Please Print): _____

Review of Systems

Patient Name:_____

CONSTITUTIONAL SYMPTOMS

Are you in good general health	YES	NO
Recent weight change	YES	NO
Fever	YES	NO
Fatigue	YES	NO
Headaches	YES	NO

EYES

Eye disease or injury	YES	NO
Wear glasses or contacts	YES	NO
Blurred or double vision	YES	NO
Glaucoma	YES	NO

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	YES	NO
Earaches or drainage	YES	NO
Chronic sinus problem or rhinitis	YES	NO
Nose bleeds	YES	NO
Mouth sores	YES	NO
Bleeding gums	YES	NO
Bad breath or bad taste	YES	NO
Sore throat or voice change	YES	NO
Swollen glands in neck	YES	NO
Sleep apnea	YES	NO

CARDIOVASCULAR

Heart trouble	YES	NO
Chest pain or angina pectoris	YES	NO
Palpitation	YES	NO
Shortness of breath	YES	NO
Swelling of feet, ankles, hands	YES	NO

RESPIRATORY

Chronic or frequent coughs	YES	NO
Spitting up blood	YES	NO
Asthma	YES	NO

GASTROINTESTINAL

Loss of appetite	YES	NO
Change/pain in bowel movements	YES	NO
Nausea or vomiting	YES	NO
Frequent diarrhea	YES	NO
Constipation	YES	NO
Rectal bleeding or blood in stool	YES	NO
Abdominal pain or heartburn	YES	NO
Peptic Ulcer	YES	NO

PSYCHIATRIC

Memory loss or confusion	YES	NO
Nervousness	YES	NO
Depression	YES	NO
Insomnia	YES	NO

MUSCULOSKELETAL

Joint pain	YES	NO
Joint stiffness or swelling	YES	NO
Weakness of muscles or joints	YES	NO
Muscle pain or cramps	YES	NO
Back pain	YES	NO

INTEGUMENTARY

Rash or itching	YES	NO
Change in skin color	YES	NO
Varicose veins	YES	NO
Breast lump	YES	NO
Breast discharge	YES	NO

ENDOCRINE

Glandular or hormone problem	YES	NO
Thyroid disease	YES	NO
Excessive thirst or urination	YES	NO
Heat or cold intolerance	YES	NO
Skin becoming dryer	YES	NO

HEMATOLOGICAL/LYMPHATIC

Slow to heal after cuts	YES	NO
Bleeding or bruising tendency	YES	NO
Anemia	YES	NO
Phlebitis	YES	NO
Past transfusions	YES	NO

GENITOURINARY

Frequent urination	YES	NO
Burning or painful urination	YES	NO
Blood in urine	YES	NO
Change in force/strain of urine	YES	NO
Incontinence or dribbling	YES	NO
Kidney stones	YES	NO
Sexual difficulty	YES	NO
Male-testicle pain	YES	NO
Female-pain with periods	YES	NO
Female-irregular periods	YES	NO
Female-vaginal discharge	YES	NO
Female-# of pregnancies	YES	NO
Female-# of miscarriages	YES	NO
Female ï date of last pap smear	YES	NO

Physician's Initials_____

_____

Patient Name

Address: _____

Phone #: _____ Referred By: _____

Date of Birth: _____/_____/_____ Sex: _____ Occupation: _____

Date: _____/_____/_____ Height: _____ Weight:_____ Age: _____ Left/Right Hand Dominant: _____

What parts of your body are you being seen for? _____

_____

Describe your **INJURY** (date of injury, how you were injured) or **PAIN** (when did pain begin, how long have you had pain)?

_____

_____

Have you had any treatment? _____

Have you had any testing? _____

Is there any **prior history** of same or similar complaints? If so, please describe: _____

_____

List any allergies to medication: _____

List any prior fractures and/or sprains: _____

List any prior surgeries: _____

Circle any medical problems listed below:

Hypertension/High Blood Pressure	Diabetes	Asthma	Epilepsy/Seizure Disorder	Rheumatoid Arthritis
Heart Attack	Migraines	Stroke	Cardiac Disease	Gout
Ulcers	Cancer	Anemia	Thyroid Disease	Malignant Hyperthermia
Sleep Apnea	High Cholesterol		Other: _____	

FAMILY MEDICAL HISTORY:

Hypertension/High Blood Pressure	Diabetes	Asthma	Epilepsy/Seizure Disorder	Rheumatoid Arthritis
Heart Attack	Migraines	Stroke	Cardiac Disease	Gout
Ulcers	Cancer	Anemia	Thyroid Disease	Malignant Hyperthermia
Sleep Apnea	High Cholesterol		Other: _____	

List all current medication: _____

_____

Do you smoke? _____ If so, _____ packs per day for _____ years Do you drink alcohol?_____

Office ONLY: Pain Scale: ____/10 Pulse: _____ Resp: _____ Blood Pressure: _____

Ross Center for Orthopedics

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Ross Center for Orthopedics, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information which does not include Independent Medical Examinations (IME's). This notice is effective March 25, 2013 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Ross Center for Orthopedics, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical records, serves as a:

- Basis for planning your care and treatment.
- Means of communicating among the many health professionals who contribute to your care.
- Legal documents describing the care you received.
- Means by which you or a third-party payer can verify that services billed were actually provided.
- A tool in educating health professionals.
- As source of data for medical research.
- A source of information for public health officials charged with improving the health of this state and nation.
- As a source of data for our planning and marketing.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights

Although your health record is the physical property of Ross Center for Orthopedics, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health record as provided for in 45 CFR 164.525.
- Amend our health records as provided in 45 CFR 164.528.

- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528.
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Ross Center for Orthopedics is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests that you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us or if you agree, we will email the revised notice to you.

We will not disclose your health information without your authorization except as described by this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions or would like additional information, you may contact the company's Practice Manager, 300 Creek Crossing Boulevard, Suite 307, Hainesport, New Jersey 08036 or at (609) 660-6200.

If you believe your privacy rights have been violated, you can file a complaint with the company's Practice Manager or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Practice Manager or the Office for Civil Rights. The address for the OCR is listed below.

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independent Avenue, S.W.
Room 509F, HHH Building
Washington, DC 20201

Ross Center for Orthopedics

2016

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing this document I acknowledge that I have read and/or received a copy of the Ross Center for Orthopedics HIPAA Notice of Privacy Practices

Printed Name Patient Signature Date

Ross Center for Orthopedics Use Only

Date Acknowledgement received: _____

Or

Reason acknowledgment not obtained: _____

Patient Disclosure Information

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request that confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual home.

I wish to be contacted in the following manner (check all that apply)

___Home Telephone_____

___Leave message with detailed information
___Leave message with call-back number only

Work Telephone_____

___Ok to leave message with detailed information
___Leave message with call-back number only

___Cell/Other Telephone_____
___OK to leave message with detailed information
___Leave message with call –back numbers only

___Written Communication

___OK to mail to my home address
___OK to mail to my work/office address
___OK to fax to this number_____

___Persons authorized to receive information

_____Relationship_____
_____Relationship_____
_____Relationship_____
_____Relationship_____

___I do not wish to share information

Printed Name: _____Patient Date of Birth: _____
Patient Signature: _____Date:_____
Witness: _____

Ross Center for Orthopedics
Patient Financial Policy/Assignment of Benefits

YOUR NAME: _____

Thank you for choosing our practice as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays:
All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with our billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

No-Show Appointment Fee:
If you fail to cancel a scheduled appointment at any time and just do not show up for your scheduled appointment, you will be charged a $25.00 no-show fee.

Insurance Claims:
Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company does not pay for any of your services performed at our office, you may be responsible for the complete balance of the non-payable services. If we are out of network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Our Responsibility to report Non Compliance:
It is our obligation under many of the managed care contracts to report patients who repeatedly refuse to pay co-pays, co-insurance and deductibles. Please know that if you are reported, you could possibly lose your health care benefits. Contact human resources with your employers for further clarification of your benefits and obligations.

Referrals and Authorizations:
If your plan requires a referral it is your responsibility to have that with you for the visit. Required Authorizations will be obtained by the practice, but it is your responsibility to make sure that these are in place prior to any procedure performed. If you do not have a referral, your appointment may be rescheduled or you may be requested to sign a waiver.

Workers' Compensation and Automobile Accidents:
In the case of a workersô compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service. All co pays and deductibles resulting from auto insurance payments that are under $500.00 are the responsibility of the patient. Balances not paid timely will be sent to collection. No balance under $500.00 will be held until the case settles. That is between you and your attorney.

Returned Checks:
The charge for a returned check is $25 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Minors:
The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Ross Center for Orthopedics
Patient Financial Policy/Assignment of Benefits

Outstanding Balance Policy/Past Due Accounts:
It is our office policy that all past due patient balances be sent two statements. If payment is not made on this account, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, this may result in reporting you to the credit bureau or filing for a judgment in small claims court or other collection activity. The person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

Disability Forms:
At Ross Center for Orthopedics, our patients are at the center of all that we do. We are committed to providing the highest quality care during all stages of your treatment. With this in mind, we want to share our process for completing Disability and FMLA forms. Effective May 1, 2016, there will be a $15.00 fee for completion of all disability forms including, but not limited to, FMLA forms and insurance disability forms, excluding state issued forms. You can deliver these forms to our Hainesport office. Please note that payment for completion is expected at the time that the forms are dropped off. This is payable by cash, check or credit card. All completed forms will be mailed or faxed to the disability carrier/employer as indicated by the patient, or may be picked up at our office at your convenience. Please allow 5-7 business days for processing.

Financial Assistance:
Our office treats patients regardless of financial status. If you have no insurance, have maximized your benefits, have a high deductible or you are currently medically or financially indigent but not eligible for Public Assistance or Medicaid, please ask to speak with the Office Manager. You will need to provide a copy of last yearôs tax returns and current pay check stubs to be considered for assistance with our office.

I, _____ authorize all information regarding my benefits under any insurance policy relating to any claim be released to Ross Center for Orthopedics, LLC. I authorize Ross Center for Orthopedics, LLC to file insurance claims and lawsuits on my behalf for services rendered to me. I direct that all such payments go directly to Ross Center for Orthopedics, LLC. I authorize Ross Center for Orthopedics, LLC to act on my behalf and report any suspected violation of proper claim practices to the proper regulatory authorities. The above has been explained to my full satisfaction and I understand its nature and effect and exercise it voluntarily.

I have read the above financial policy and understand my financial responsibility to my healthcare provider.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____