Ross Center For Orthopedics
Motor Vehicle New Patient Form

Today's Date	Referring Doctor	Primary Doctor
Last Name First Name Middle		Marital Status (Circle One) Single Married Divorced Separated Widow

Street Address	City	State	Zip Code

Date of Birth / /	Age	Sex M or F	Social Security # - -	Home Phone	Cell Phone

Occupation	Employer	Employer's Phone	Email Address

How did you hear about our office? (Circle One) Doctor's Office Family Member Friend Yellow Pages
Internet Insurance Plan Other

Insurance Information

Motor Vehicle Accident		Worker's Compensation	
Insurance Carrier:		Insurance Carrier:	
Date of Accident	Claim #	Date of Accident	Claim #
Adjuster's Name:		Adjuster's Name:	
Address City State Zip		Address City State Zip	
Phone # Extension	Fax #	Phone # Extension	Fax #
Attorney's Name:		Attorney's Name:	
Phone #	Fax #	Phone #	Fax #

Indicate Primary Insurance	Subscriber's Name:	Secondary Insurance:	Is your injury due to a Slip and Fall Case? Y or N
○ Aetna ○ Amerihealth ○ Cigna ○ Keystone ○ Horizon BC/BS ○ Oxford ○ United Healthcare ○ Tricare ○ Medicare ○ Other	Subscriber's D.O.B:	Subscriber's Name:	Where did the accident occur?:
	Subscriber's SSN:	Subscriber's DOB:	
	ID #:	Subscriber's SSN:	Attorney's Name:
	Copay:	ID #:	Attorney's Phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize RCFO or insurance company to release any information required to process my claim.

Patient Signature: ______________________________ **Date:** ____________________

Date: _____/_____/_____ **Height:** _________ **Weight:**________ **Age:** ________ **Left/Right Hand Dominant:** ________

Date/time of your accident: _____/_____/_____ @ _________ am or pm **City/State/Street:** ___________________________

Your position in the vehicle (driver, etc.): ____________________________ **Were you wearing a seatbelt?** ________________

Describe the accident: ____

Describe your body movement at the time of the impact: ____

If you were the driver, did you have both hands on the steering wheel? YES NO OTHER

If you were the passenger, did you brace with your hands on impact? YES NO OTHER

Did any part of your body come in contact with any part of the vehicle? YES NO OTHER
If yes, please describe: ____

Was your car **MOVING** or **STOPPED** Was your car **IN TRAFFIC** or **STOPPED**

Type of vehicle you were in: CAR SUV TRUCK BUS MOTORCYCLE OTHER: _____________________

If moving, what was your approximate speed at the time of impact? ____

Were you **HIT** or did you **HIT ANOTHER VEHICLE**?

If you were hit, where: REAR-ENDED BACK DRIVER-SIDE HEAD-ON OTHER
FRONT DRIVER-SIDE FRONT PASSENGER-SIDE BACK PASSENGER-SIDE

Describe body movement at time of impact: ____

How many vehicles were involved in the accident? 1 2 3 4 Other (Describe): _____________________

Did you lose consciousness? YES NO If yes, how long? ____

What body part(s) were injured during the accident? ____

____

Describe your current symptoms: ____

____

Are there any complaints of numbness or tingling? ____
Did you go to the hospital after the accident? YES NO If yes when? ____

Were you taken by ambulance? YES NO **Name of Hospital:** _____________________________________
Did you seek treatment with a Doctor after the hospital? YES NO

Patient Name: ____ **DOB:** ___________

NAME OF DOCTOR	SPECIALTY	DATE OF 1st VISIT	STILL TREATING?

Have you had any testing performed?

TYPE OF TEST	FACILITY/LOCATION	BODY PART
X Rays		
MRI		
CT Scan		
EMG		

Did you have any Physical Therapy Treatments? YES NO If yes, Where? ____

When did you start treatments? ______________________________ **Are you still currently going?** YES NO

What type of treatments have you received? HOT PACKS ICE OTHER

ELECTRIC STIMULATION EXERCISE ULTRASOUND TRACTION MANIPULATION

How often did you or do you go? _____________________________________ **Is it helping or did it help?** YES NO

History of Prior Injuries

Have you had any prior motor vehicle accidents/significant injuries? YES NO

If yes, when? ____

What areas of the body were involved in any PRIOR accident? ____________________________________

____

Were these injuries resolved prior to your current injuries? YES NO

If no, what complaints remain? ____

Are you still treating for these injuries? YES NO

List any allergies to medication: ____

List any fractures or sprains: ____

List any surgeries: ____

MEDICAL HISTORY (Circle any history of personal 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 (Circle any history of family 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: ________________________________	

List all current medication: ____

Do you smoke? _________ **If so,** ______ **packs per day for** ______ **years.** **Do you drink alcohol?**______**If so,** ____**drinks per week.**

Office Only: Pain Scale____/10 Pulse:_____ Resp :___________ Blood Pressure: _______
Previous Patient?:______________ Date of Last Visit:_____________ Reason:_____________

Ross Center for Orthopedics

HIPAA Notice of Privacy Practices

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.

Patient Name: ____ **DOB:** ___________

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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) 267-2333.

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

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/Cell Phone #: ____________________________________

_____ OK to leave message with detailed information
_____ OK to leave message with call-back number only
_____ I prefer not to be contacted at work

Work Phone #: ______________________________________

_____ OK to leave message with detailed information
_____ OK to leave message with call-back number only

Written Communication

_____ OK to mail to my home address
_____ OK to mail to my work/office address
_____ OK to fax to this number: _____________________________

Person(s) authorized to receive information

Name: ____ **Relationship:** _____________________________

Name: ____ **Relationship:** _____________________________

None: _______

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	DOB	Patient Signature	Date

********For Ross Center for Orthopedics Use Only********

_______________________________	_______________	_____________________________
Witness	Date Acknowledgement Received	Reason Acknowledgement Not Obtained

Ross Center For Orthopedics
Patient Financial Policy/Assignment of Benefits

Patient Name: ____ **DOB:** ____________________

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.

Card On File: All Patients must place a card on file at the initial office visit regardless of case type. The patient authorizes Ross Center for Orthopedics to charge the card on file up to $100.00 dollar in the event they have any remaining balance from prior visits.

No-Show/ Late Cancellation Fee:
If you fail to cancel a scheduled appointment prior to 4:00 PM the day before closing or no show to an appointment you will be charged a $50.00 fee. The Patient authorizes Ross Center for Orthopedics to charge the card on file each event that this occurs.

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 workers' 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 $50 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.

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 Patient authorizes Ross Center for Orthopedics to charge the card on file $100.00 dollars a month until the patients balance is satisfied or until a payment plan is agreed upon with the office.

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 $20.00 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 10 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 year's 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: _________________