



Financial Policy

Thank you for choosing us as your orthopaedic specialists. We are committed to providing you the best possible care, and we are pleased to discuss our professional fees with you at any time. The following is a statement of our Financial Policy which we require you to read and sign prior to any medical services.

- FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE.
- ALL PAYMENTS WILL BE COLLECTED UPON CHECKING IN FOR YOUR SCHEDULED APPOINTMENT.
- WE ACCEPT CASH, PERSONAL CHECKS, VISA, AND MASTERCARD.

INSURANCE

- If we are a participating provider with your insurance plan you are responsible for all co-payments deductibles and any non-covered services. As a courtesy we will file insurance claims with most insurance carriers, provided you have supplied us with the proper information.
- If we are NOT a participating provider with your insurance plan you are responsible for full payment at time of service. If you need to file your own insurance our office will provide you with the proper documentation.
- Bills for surgery will not include charges of anesthesia, hospitalization, or laboratory test. These are billed separately, from the facility where the surgery is performed.

MINOR PATIENTS

The adult parent or guardian accompanying the minor is responsible for payment of the minor patient's account regardless of who the insurance policy holder is. For unaccompanied minors non-emergency treatment can be denied until a parent or guardian is present or we have written permission for treatment and payment of the account period.

WORKMAN'S COMPENSATION

All workmen's compensation claims must be verified in writing by the employer. Verbal or telephone verifications are not acceptable. If you have seen another physician for the same complaint an authorization for a change of physician must be verified on your company's form.

PERSONAL INJURY WITH ATTORNEY

If you are being represented by an attorney or a third party payer, we will provide you with the proper information to file your claim. You are responsible for full payment to our office at the time services are rendered.

AUTOMOBILE ACCIDENT

If you were in an automobile accident and you have "Med-Pay" automobile insurance our office will provide you with the proper documentation to file the claims. It will be your responsibility to file the claims. If you have health insurance we will file a claim for all professional services received.

FORMS:

We will be happy to complete any medical forms. Payment of \$20.00 is required prior to completion of form(s). Please allow 7-10 business days for your form to be completed. We will notify you when the form is ready.

MISSED APPOINTMENTS

Failure to give 24 hour notice of cancellation of your appointment will result in a \$20.00 fee billed directly to you. We will not bill your insurance company for this amount. You will be responsible for prompt payment of this fee prior to being seen at your next scheduled visit.

COLLECTIONS

If your account balance becomes past due and is sent to an outside collection agency, you will be responsible for any additional fees incurred.

All monthly statements are due and payable in full upon receipt.

All returned checks are subject to a \$25.00 service fee.

THANK YOU FOR UNDERSTANDING THE NECESSITY OF OUR FINANCIAL POLICY. IF YOU NEED TO MAKE SPECIAL PAYMENT ARRANGEMENTS THIS NEEDS TO BE BROUGHT TO OUR ATTENTION PRIOR TO BEING EXAMINED. MY SIGNATURE BELOW INDICATES THAT I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

Signature of Patient or Guardian

Date



3009 New Bern Ave.
Raleigh, NC 27610
919-232-5020
919-232-5023 Fax

CONSENT TO LEAVE MEDICAL INFORMATION WITH SOMEONE OTHER THAN THE PATIENT

I am authorizing the personnel at Wake Orthopaedics, LLC to leave information related to my medical care with others if I am not available.

Check all that apply:

_____ I authorize that information can be left with my wife/husband/significant other.
Name of person: _____.

_____ I authorize that information can be left on my answering machine (phone #): _____.

_____ I authorize that information can be left on my voice mail (phone #): _____.

_____ Other:
I authorize that information can be left:
_____.

I understand that this authorization will be valid until I give written notification otherwise.

Signature

Date



Patient Information Form

First Name		Middle Initial	Last Name		
Street Address			City	State	Zip Code
Mailing Address (if different from above)			City	State	Zip Code
Home Phone ()	Work Phone ()	Date of Birth	Age	Social Security #	
Marital Status	Gender Male Female	Employer or School/Address			
Family Physician			Referring Physician		
Person to Contact in Case of Emergency		Relationship	Phone Number ()		
Spouse/Parent Name		Social Security #	Phone Number ()		
Spouse/Parent Address		City	State	Zip Code	

Insurance Information

Insurance Company	Policy Number
Subscriber's Name	Subscribers Social Security # & DOB
Subscriber's Employer	
Secondary Insurance Company	Policy Number
Subscriber's Name	Subscribers Social Security # & DOB

Problem Information

Injured/ Painful Area: _____ () Right () Left Date of Injury/Onset: _____	
Medication Allergies: _____	
Was this a motor vehicle accident? Yes No	If yes, provide name of Insurance Company
Was this a work-related injury? Yes No	Employer at time of injury

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT TO PAY PROVIDER DIRECTLY:

I authorize the release of information to my referring or family physician and/or that which is necessary to file claims to the insurance carrier and the billing of my account for payment. I understand that you may be transmitting any records electronically, and I absolve all parties of any liability relating to such transmission of said records. I authorize my insurance carrier to make payment directly to Wake Orthopaedics, LLC. I understand that I am responsible for any remaining balance due on my account not covered by my insurance carrier. Thus, if the account balance is not satisfied within 30 days after the first notification, the account may be referred for legal action. I consent to the treatment rendered to me under the general/special care of the attending physician.

Signature _____ Date _____

HIPAA Notice of Privacy Practices



3009 New Bern Avenue
Raleigh, N.C. 27610
919-232-5020

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

Contact for Questions or Complaints

Anthony Reyes
Wake Orthopaedics
218 Ashville Ave, Ste. 10
Cary, NC 27511
919-235-0616 Ext. 304

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Wake Orthopaedics, LLC

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____, have received a copy of Wake Orthopaedics, LLC Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my protected health information (PHI).

Signature of Patient

Date

Patient Chart #

Relationship to Patient (if signed by a personal representative of patient:

Patient Personal Representative

Date

Witness

Date



Patient Medical History

Patient: _____

Date: _____

Chart #: _____

Physician: _____

I. Please check all of the following signs/symptoms that you have ever experienced.

Table with 8 columns: Symptom, YES, NO, YES, NO, YES, NO. Rows include Weight Loss, Fever, chills, Appetite change, Joint Pain, Muscle Pain, Gout, Headaches, Redness/swelling of a joint, Frequent falls, Seizures, Stroke, Numbness, Kidney Disease, Hepatitis, HIV, Thyroid Disease, Vision, Hearing, Skin rashes/bed sore, Pneumonia, Fatigue, Nausea, Vomiting, Diarrhea, Frequent urination, Shingles, Anxiety, TB, Diabetes, High Blood Pressure, Leg swelling, Low Blood Pressure, Chest pain, Fainting spells, Shortness of breath, Asthma, Cough, Memory loss, Kidney stones, Anemia, Blood clots, Seasonal Allergies, Hallucinations, Depression, Heart Murmur.

Primary Care Physician: _____

Referring Dr.: _____

II. Past Medical History

Have you ever had or do you have any:

- Illnesses: _____
Injuries: _____
Drug Allergies: _____
Operations: _____

List Current Medications: _____

III. Social History

Occupation: _____

Tobacco? YES NO Packs/day _____

Alcohol? YES NO Amount _____

Daily Activities: Independent _____ Need Help _____

Walking: Normal _____ Cane/Walker _____ Wheelchair _____

IV. Family History

Does anyone in your immediate family (mother, father, siblings, children) suffer from any of the following? (Please check and identify which family member)

- Heart Disease: _____ Cancer (type): _____ Diabetes: _____
Lung Disease: _____ Stroke: _____ Tuberculosis: _____
Alzheimer's: _____ Scoliosis: _____ Parkinson's: _____
Arthritis: _____ Seizures: _____ Multiple Sclerosis: _____

Patient Signature: _____

Date: _____

All items on this page were reviewed by _____ (MD/PA initials) on _____ (date).