SUMMIT ORTHOPAEDICS, LLP
PATIENT PROFILE

Please complete this form and return it to the front desk. Thank you.

Patient's Name: ______________________ Date of Birth: _____________________

Mailing Address: ______________________ Social Security #: _____________________

Apt/Unit #: ______________________ Gender: ☐ Male ☐ Female ☐ Other

City/State/ Zip: ______________________ Marital Status: _____________________

Cell Phone: ______________________ Primary Language: _____________________

Home Phone: ______________________ Interpreter Needed: ☐ Yes ☐ No

Email Address: ____

Guarantor/Parent/Guardian's Name: ______________________ Birthday: ____________

Address: ____ Social: ______________

Relationship to Patient: ___________________________________ Phone: ______________

Employer: _______________________ Primary Care Doctor: ___________________

Address: _______________________ Clinic Name: ___________________

Phone: _______________________ Clinic Phone: ___________________

Primary Insurance: ____________________ Workers-Comp: _____________________

Secondary Insurance: ____________________ Attorney: _____________________

Date of Injury: ____________ Body Part(s): _______________________ ☐ Right ☐ Left

Signature: ___________________________ Today's Date: ___________________

ACKNOWLEDGMENT AND CONSENT

I understand that **Summit Orthopaedics, LLP,** (referred to below as “This Practice”) will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician’s efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice’s Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By:____ Date:________________
(Patient)

-OR-

By:____ Date:________________
(Patient representative)

Description of Representative’s Authority:____

Patient has refused to sign this agreement: ____
Summit Orthopaedics, LLP Staff Initials/Date

Summit Orthopaedics, LLP
Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to the success of your medical treatment and care. Please understand that payment of your bill is a part of this treatment and care. Our fees for services, including office visits and surgeries, are based on the level of professional skill required, the severity and complexity of the injury or illness as well as the time spent treating you. Please do not hesitate to inquire about the charges for our services, however a precise estimate in advance may not be possible.

Insurance & Insurance Collection:

We make every effort to make sure your paperwork is filed accurately and promptly. We may bill your insurance as a courtesy at no expense to you. However, we will only bill insurance that has appropriate documentation presented at the ***time of service***. Secondary or other insurances that you may have must be presented at ***time of service*** if it is to be billed.

Each physician in this practice bills separately. You will not receive a statement until there is a patient balance. You may receive more than one statement if you see more than one physician in our office.

It is the patient's responsibility to inform us of any changes in insurance and to present the appropriate documentation. Failure to do so could result in any balance being transferred to patient responsibility.

If your insurance company does not respond within 30 days, as required by law, you may be held responsible for all charges. We will not submit more than two claims to your insurance company. Failure of your insurance company to respond will result in automatic transfer of the balance to your responsibility.

In order to provide you with the highest quality service, while keeping our billing costs low, we offer paperless patient billing through EASY PAY. We simply maintain your credit, debit, or check card number on file to satisfy all co-pays, deductibles and balances not covered by your insurance. You have been given a form to set up this option, please fill it out and return the form with the rest of your paperwork. Our Billing Personnel will be more than happy to give you more information about EASY PAY should you have any questions.

WE ACCEPT ALL MAJOR CREDIT CARDS, DEBIT CARDS,
CHECK CARDS, CHECKS* AND CASH.

Please understand that all personal balances are due within 30 days of receipt of the statement or at your next scheduled visit, whichever comes first. We strongly recommend that you use EASY PAY to satisfy your balance as it becomes due. *Any returned checks will result in a $25.00 charge to your account and no further checks will be accepted.

Participating Provider Plans:

HMO PLANS: All co-pays must be satisfied each and every visit. There can be no exceptions due to contracting and uniform compliance rules. ***You*** are responsible for getting proper referral information in advance of your appointment. In the event that you do not have a valid referral at time of service, you may reschedule or sign a disclaimer that states you understand that there is not a valid referral in our office and that you will be responsible for the charges in the event your insurance company does not pay for the services. Failure to obtain a referral or refusal to sign the disclaimer may result in rescheduling your appointment until this procedure is complete.

PPO PLANS. We have agreed to accept the discounted rate from your plan, however all co-insurance is your responsibility. Patient balances are due within 30 days of receipt of the statement or next office visit, whichever is earlier.

Non-Contracted or Indemnity Insurance Plans:

We may bill your insurance as a courtesy. Our office, as a convenience and a service to you, will absorb all costs incurred for billing. However, failure to present appropriate documentation regarding your insurance coverage or changes in insurance coverage will result in balances being transferred directly to patient responsibility. In the event your insurance company does not respond within 30 days, as required by law, you may be held responsible for all charges.

PLEASE SIGN BACK OF THIS FORM

Secondary Insurance:

Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary carrier as a courtesy, if ***and only if*** proper information is received ***at time of service***. You are responsible for any balances after your insurance(s) has cleared.

Payments sent directly to Patient:

In the event your insurance company sends funds directly to you instead of the physician, you can endorse the check and send it directly to our office, or forward a personal check for no less than the full amount sent by the insurance company, along with copies of the documentation supporting that payment to insure your account is properly credited. Funds received by the subscriber results in automatic transfer of the complete balance to patient responsibility, no secondary insurance will be billed and no payment plan considerations will be given on the portion of funds received by the patient or subscriber.

Usual & Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.

Minor Patients and/or Divorce Decrees:

This office is not a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment.

I have read, understand and agree to the above Financial Policy. I understand that the charges not covered by my insurance company, as well as co-payments and deductibles, are my responsibility. I understand that in the event any unpaid balance is placed for collection with any third party collection agency a fee of 35% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees and any other fees so stated elsewhere.

I authorize my insurance benefits be paid directly to the provider.

I authorize my physician to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I authorize my physician to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

X______________________________ ______________________________
Signature of Patient or Responsible Party Date

______________________________ ______________________________
Please print Patient's name Patient ID

Patient has refused to sign this agreement: ______________________________
Summit Orthopaedics, LLP Staff Initials/Date