Pacific Rim Orthopaedic Surgeons New Patient Packet

All forms must be completed and signed. Please print legibly.

Physician Seen: _____ Date: _____

Legal Name: Last _____ **First** _____ **M.I.** _____

Age: _____ **DOB:** _____ **Soc Sec#** _____ **Sex:** M / F **Marital Status:** M S D W

If Patient is a minor, name of parent present: _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Ph# _____ **Cell Ph#** _____ **Email:** _____

Occupation: _____ **Employer:** _____ **Ph#** _____

Spouse's Name: _____ Primary Language: _____ Secondary: _____

Emergency Contact: _____ Ph # _____ Relationship: _____
(not residing with you)

Other Family Members Seen Here: _____

PCP: _____ Consult Requested by: _____

Insurance Information

Primary Insurance: _____ Subscriber's Name: _____ DOB: _____

Subscriber ID# _____ Group# _____ Copayment: $ _____

Secondary Insurance: _____ Subscriber's Name: _____ DOB: _____

Subscriber ID# _____ Group # _____ Co-Payment: $ _____

Injury Information Circle One: Sport / Other Work Related Auto Accident

Sports/other injury: Date of injury/onset of symptoms: _____ Part of body injured: _____

Work related injury: Yes / No **Have you filed a claim?** Yes / No **Date of injury:** _____

Claim Number: _____ **Part of body injured:** _____ **(Circle one) Right / Left**

Employer: _____ **Contact:** _____ **Phone #.** _____

*******If auto accident injury, please ask Receptionist for Auto Accident Report*******

I hereby authorize Pacific Rim Orthopedic Surgeon LLC to release to my insurance company any medical information necessary to assist in the processing of my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf directly to the providers as Pacific Rim Orthopedic Surgeons LLC. I understand my insurance will be billed as a courtesy and any unpaid charges for myself my minor child will be my responsibility. I further understand that this clause shall not be amended orally. I agree to pay any interest or collection fees that may be related to this account.

Responsible Party Signature: _____ **Date:** _____

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CURRENT MEDICATIONS & ALLERGIES

In our efforts to improve patient care and safety, it is required that you complete this list with any current medications you are taking including the dosage, how often those medications are taken and the reason for taking them. Please include any known allergies to medications, latex, iodine, food, or metals.

Patient's Name: _____ **Date of Birth**: _____

I) CURRENT MEDICATIONS:

Primary Care Physician:_____

Name of Medication	Dosage	How often	Reason

II) OVER THE COUNTER MEDICATIONS: INCLUDING HERBALS AND DIETARY SUPPLEMENTS

Name of Medication	Dosage	How Often	Reason

III) ALLERGIES:

_____

Patient's Signature: _____ Pharmacy Name:_____

Date: _____ Pharmacy Phone #:_____

Pharmacy Fax #:_____

Updated on (date): _____ MA Initials _____

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FINANCIAL POLICY

Arrangements for payment for medical services provided by a practitioner of Pacific Rim Orthopaedic Surgeons (PROS) must be made in advance. We accept cash, personal checks, debit cards, Visa, MasterCard and American Express credit cards. We are happy to provide an estimate of charges for your visit(s) or surgery upon request.

We must emphasize that as an orthopedic practice, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the date services are rendered. **Therefore, it is often necessary for you to inquire and explore your benefits with your insurance carrier.** We realize that temporary financial problems may affect timely payment of your account and if such problems do arise, we encourage you to contact our business office for assistance in the management of your account.

PATIENTS WITH INSURANCE

Clinic Visits and Surgery Charges - For patients who have provided the information necessary to bill their insurance company, PROS will bill the insurance carrier for the services provided. **Patients are responsible for co-pays, deductibles, coinsurance balances, and any known services not covered by your insurance, at the time of the clinic appointment.** There may be a balance after the insurance carrier has settled their part of the claim and the patient will be billed for this balance. We encourage patients to know their policies and to become familiar with their orthopedic benefits. This will help to avoid any billing surprises.

SELF-PAY PATIENTS

***Clinic Visits* - Patients who are self-pay are required to pay at the time of service.** A New Patient visit charge is $250.00. An Established or Follow-Up visit charge is $150.00. PRP Injections must be paid in full at time of visit. You will be billed for other services obtained during your visit. If paid in full at the time of visit, a 10% discount will be given to additional services obtained during your visit. The discount does not apply to the visit charge, or to patients with prior balances unless the entire account is paid in full. In some instances, a Payment Plan Agreement may be approved prior to the day of service. In this case, the patient will be required to sign a payment plan agreement and provide a minimum of $100 as a down payment at the clinic visit.

Surgery Charges - A deposit of 50% of the anticipated physician fee is required at least one week prior to surgery.

SELF-PAY EMERGENCY DEPARTMENT PATIENTS ON THE PEACEHEALTH BRIDGE ASSISTANCE PROGRAM

Clinic Visits –

- When a physician has provided direct care for a patient while on call at PeaceHealth and the patient is on PeaceHealth Bridge Assistance, the Pacific Rim physician charge will be adjusted to equal the Group Health fee schedule. A Payment Plan Agreement may be arranged with the Billing Department.
- When a patient is referred to the clinic from the Emergency Department and the physician did not provide direct care while on call, the policy under Self-Pay Patients above will apply with the charge adjusted to equal the Group Health fee schedule. A Payment Plan Agreement may be arranged for the patient.

PATIENTS USING MOTOR VEHICLE ACCIDENT (MVA) INSURANCE

Clinic Visits **-** We will bill the MVA insurance one time and after 30 days of non-payment the balance will become the patient's responsibility. We do not deal with attorneys or wait for payment from a settlement. If the Personal Injury Policy exhausts on the MVA insurance, we will bill the private insurance or the private party if the information has been provided.

Surgery Charges **-** These payments are handled on a case by case basis and will need to be negotiated with the Clinic Administrator or Billing Department at least one week prior to surgery.

SURGERY/GLOBAL SURGICAL PACKAGE

Medical billing for all major surgical procedures (i.e. fracture repair, joint replacement, etc.) generally involves a set fee for the procedure and follow up visits for a period of 90 days following treatment. This is commonly referred to as a "Global Surgical Package" and does not include the initial consultation or evaluation by the surgeon to determine the need for major surgery; visits unrelated to the diagnosis for which the surgical procedure is performed; diagnostic tests and procedures including x-rays; treatment for post-op complications that require a trip to the operating room; additional cast applications and supplies; any braces or splints that may be required; and a more extensive procedure if the less extensive procedure fails.

BAD DEPT ACCOUNTS

Pacific Rim Orthopaedic Surgeons, LLC, or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility, may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to cellular/wireless telephone numbers, which may result in my incurring fees for the call or text message. The collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. The collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

Note: Balances in collections must be paid in full prior to further treatment. The collection agency and your health insurance company will be called to verify payment and current benefits prior to scheduling an appointment. If you are without insurance, the self-pay policy listed above applies. If you have filed for bankruptcy, a $450.00 deposit is required for self-pay and/or non-contracted services. Internal unpaid balances must be paid prior to more appointments being made.

NON-SUFFICIENT FUNDS

A $25.00 charge will be made for non-sufficient funds.

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Pacific Rim ORTHOPÆDIC SURGEONS

CANCELLATION, NO-SHOW & LATE PATIENT POLICY

Pacific Rim Orthopaedic Surgeons (PROS) reserves the right to discharge a patient from the practice after 3 or more consecutive cancellations, or 2 or more no-shows within a 12 month rolling period.

If a patient cancels three consecutive appointments within 24 hours of his/her appointment; or no-shows two times within a 12 month rolling period; the patient will not be scheduled again, until s/he speaks with the Clinic Administrator. The Clinic Administrator will work with the patient's physician to decide if the patient may return to the practice. The Clinic Administrator will notify the patient of the final decision. If the patient is discharged from the practice a letter will be sent to the patient by certified mail.

Late Patient Policy: we require that New Patients arrive to their first appointment at least 15 minutes before the scheduled appointment time, to allow ample time to complete any paperwork and insurance information. For all other appointments, patients should arrive 10 minutes before the scheduled appointment time. So that all of our patients have enough time to meet with their provider, and in order to keep our providers running on time, PROS reserves the right to reschedule any patient who does not arrive within these timeframes.

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Pacific Rim ORTHOPÆDIC SURGEONS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by our physicians, staff members, or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

Payment. Your health information may be used to seek payment from your health plan, other sources of coverage such as an automobile insurer, or credit card companies that you may use to pay for your services. For example: your health plan may request and receive information regarding dates of service, the services provided, and the medical condition being treated.

Healthcare Operations. Your health information may be used as necessary to support the day-to-day activities and management of ***Pacific Rim Orthopaedic Surgeons, LLC.*** For example: information on the services you have received may be used to support budgeting and financial reporting, activities to evaluate and promote quality of care to ensure that our practice is meeting state and federal guidelines and laws designed to protect your healthcare information.

Law Enforcement. Your health information may be disclosed to law enforcement agencies without your permission to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public-Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example: our practice is required to report certain communicable diseases to the State of Washington Department of Health.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Appointment Reminders. Your health information will be used by our staff to call/mail you appointment reminders.

Information about treatments: Your health information may be used to send you information on the treatment management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may be of interest to you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information
- The right to request an amendment or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Pacific Rim Orthopaedic Surgeons Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Andrea Vitalich, our Clinic Administrator.

Complaints and Contact Person

If you would like to submit a comment or complaint about our privacy practices, or obtain additional information about our privacy practices, you can do so by sending a letter outlining your concerns to the person listed below. You will NOT be penalized or otherwise retaliated against for filing a complaint.

Andrea Vitalich, Clinic Administrator
Pacific Rim Orthopaedic Surgeons
2979 Squalicum Parkway, Suite 203
Bellingham, WA 98225
Phone: 360-733-7670, ext. 1010
Fax: 360-647-1901

***You may also contact the Department of Health and Human Services directly at:**

Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
Toll Free Phone: 1.877.696.6775

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Pacific Rim ORTHOPÆDIC SURGEONS

PATIENT ACKNOWLEDGEMENT FORM

___ I acknowledge that I have received a copy of the **PROS Financial Policy** from the Receptionist. I have read, understand, and agree to the provisions of the policy.

___ I acknowledge that I have received a copy of the **PROS Cancellation, No-Show & Late Patient Policy** from the Receptionist. I have read, understand, and agree to the provisions of the policy.

___ I acknowledge that I have received the written **Notice of Privacy Practices** from the Receptionist. I have read, understand, and agree to the provisions of the policy.

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

Cell Phone:

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

Work Telephone:

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

Written Communication

___ OK to mail to Home address ___ OK to mail to Work address

___ OK to fax to this number (____) ____ - _____ ___ OK to send information to Electronic Health Exchange

___ OK to E-mail. E-mail Address _____

I consent to allow secure release of information by phone or Electronic Health Record to:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

_____ **Date** _____

Patient Signature

_____ **Date** _____

Parent/Legal Guardian Signature

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