TRINITY

ADULT AND PEDIATRIC ORTHOPEDIC SPECIALISTS

New Patient Packet

Patient Name: ______________________________________ **DOB:** _________________

Social Security Number: ______-_______-_________ **Gender:** ☐ Male ☐ Female

Address: ____

City: __________________ **State:** __________________ **Zip:** __________________________

Home #: _____________ **Cell #:** _________________ **Work #:** _________________

Email: _______________________________________ **Preferred Language:** ________________

Race:	☐ African American	☐ Native Hawaiian/ Pacific Islander	☐ American Indian/Alaskan Native
☐ Asian	☐ Hispanic	☐ White	☐ Other:
Ethnicity:	☐ Hispanic or Latin Decent	☐ Not Hispanic or Latin Decent	☐ N/A

Emergency Contact Information

Name: ____________________________ Relation: ________________ Phone: ________________

Release of Information:

(Medical Information may be released to the following individuals)

Name: ____________________________ Relation: ________________ Phone: ________________

Name: ____________________________ Relation: ________________ Phone: ________________

Primary Insurance:

Primary Company: ___________________________________ Insured's Name: ________________

Policy #: ________________________ Group #: ___________________ Insured's DOB: ___________

Secondary Insurance:

Primary Company: ___________________________________ Insured's Name: ________________

Policy #: ________________________ Group #: ___________________ Insured's DOB: ___________

Guardian/Information: (MUST BE COMPLETED FOR ALL MINORS)

Name: ______________________________________ Relationship to minor: ___________________

Social security number: ____-____-_______ DOB: _______________ Phone #: ___________________

I agree that all information provided is correct and true to the best of my knowledge.

Patient Signature: ________________________________ Date: _____________________________

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION:

I authorize Trinity Adult & Pediatric Orthopedic Specialists PLLC to release any medical information requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my medical care.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:

I authorize the release of any medical information necessary to process any claim associated with Trinity Adult & Pediatric Orthopedic Specialists PLLC with respect to my medical care. I permit a copy of this authorization to be used in the place of the original.

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of benefits to be paid directly to Trinity Adult & Pediatric Orthopedic Specialists PLLC. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney fees.

CONSENT FOR TREATMENT:

I hereby authorize the health care providers at Trinity Adult & Pediatric Orthopedic Specialists PLLC to perform a physical examination and to provide any medical treatment deemed necessary. This includes but not limited to all required medical examinations, x-rays, and/or medical/ surgical procedures.

NOTICE OF PRIVACY PRACTICES:

Trinity Adult & Pediatric Orthopedic Specialists PLLC is required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing below indicated acknowledgement of receipt of our office's Notice of Privacy Practices.

AUTHORIZED SIGNATURE:
I authorize that I have read this document and completed the requested information to the best of my ability.

Printed Patients Name: ______________________________

Patient/Guardian Signature: _____________________________ Date: ____________________

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FINANCIAL POLICY

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, Master Card, Discover, American Express and Care Credit. As a courtesy,
It is our policy to bill your insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand:

(PLEASE INITIAL EACH OF THE FOLLOWING)

______ 1. Surgery deposit of $500.00 will be due for patients with unmet deductible and/or co-insurance. (Exceptions may be made for patients with 100% coverage). The balance of your portion of the surgery will be billed to you after your insurance has finalized your claim. Surgery cancellation or no show by the patient 7 or less days prior to scheduled surgery will be charged a fee of a $100.00.

______ 2. Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees including bank service charges.

______ 3. There is a fee for copies of medical records not requested by another physician. The first 25 pages will be $25.00 and $.50 for each additional page after that. An additional charge for x-ray disc will be $25.00.

______ 4. I understand treatment may involve my doctor prescribing Durable Medical Equipment (DME) which may include but not limited to braces, custom orthotics, slings, boots, and wraps and that my insurance may not cover these items. I understand I will be ultimately responsible for payment for these items and that these items may not be returned once they have left the facility.

______ 5. Any documents or paperwork that need to be completed by our office to include. FMLA and STD (short term disability) will have a fee of $75.00 and will be ready for pick up in 7-10 business days. If expedited service is required there will be a $100.00 fee and will be ready for pickup within 2 business days. All fees must be paid prior to picking up.

______ 6. All accounts will be charged a NO SHOW fee of $50.00 should you not call within 24hrs prior to your appointment.

Patient/Guardian Signature: ______________________________ Date: ____________________

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Treatment for Fractures

All insurance companies require that our services are billed using a coding system known as CPT (Current Procedural Terminology). The codes used to describe the services performed are found in the surgery section of the CPT code book. This does not mean you had an operation, it's simply the category that the healthcare industry uses for fracture care billing. Your insurance explanation of benefits (EOB) may list our services as surgery. This is appropriate based on medical billing guideline standards.

• Payment is due at time services are rendered.

According to CPT guidelines, fracture care is billed as a packaged or global service. Meaning, at the time of initial care, a bill is generated including:

- Treatment of the fracture.
- First cast or splint application (this does not include supplies)
- 90 days of normal, uncomplicated, follow-up care

There are items that are not included in the packaged service. These services will be billed In addition to the fracture care code:

- Initial evaluation by the orthopedic surgeon.
- X-rays
- Casting supplies and/or support/braces applied

Waterproof casting materials is not covered by your insurance. Health plans consider the application of this material a patient convenience rather than medically necessary.

Acknowledgement: ______________________________ Date: ____________________

Printed Name of Parent: ______________________________

Printed Name of Patient: ______________________________