



ORTHO CENTER

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PATIENT INFORMATION

(Please note the information being requested is for the PATIENT)

Patient Name: _____ Sex: M F DOB: _____ Age: _____

Home Phone: (____) ____-____ Cell Phone: (____) ____-____

Home Address: _____ Social Security #: _____

City: _____ State: _____ Zip: _____ Marital Status: S M W D

Email Address: _____ Race: _____ Ethnicity: _____

Employer's Name: _____ Phone #: _____

IF PATIENT IS UNDER 18 YEARS OF AGE, Responsible Party Information

Responsible Party Name: _____ Sex: M F DOB: _____

Relationship to the Patient: _____ Social Security #: _____

Billing Address: _____ Phone: (____) ____-____

City: _____ State: _____ Zip: _____

PRIMARY INSURANCE INFORMATION

Subscriber Name: _____ Sex: M F DOB: _____

Subscriber Home Address: _____

Relationship to Patient: _____ Social Security #: _____

Insurance Name: _____ Policy: _____

Claims Address: _____ Group #: _____

City: _____ State: _____ Zip: _____ Phone: (____) ____-____

PLEASE TURN OVER.....

Patient Information Continued...

SECONDARY INSURANCE INFORMATION

Subscriber Name: _____ Sex: M F DOB: _____

Subscriber Home Address: _____

Relationship to Patient: _____ Social Security #: _____

Insurance Name: _____ Policy #: _____

Claims Address: _____ Group #: _____

City: _____ State: _____ Zip: _____ Phone #: (____)____-_____

First & Last Name of Primary Care Physician: _____

First & Last Name of Referring Physician: _____

Do you have an Advanced Directive: Yes No

If yes, please select one from the following options:

- Do not intubate Do not resuscitate Full code Health proxy on file
 Durable Power of Attorney for healthcare Living will Organ or Tissue Donor
 Surrogate decision make

Please complete if your visit today is a result of an accident. Type of Accident:

- Auto Accident Workers Comp Accident
 Slip and Fall Accident Sports Related Accident Assault/Battery

Date of Accident: ____/____/____ Location of Accident (City & State): _____

If Sports Related Accident, name of school you attended: _____

Name of Attorney representing you: _____

How did you hear about us?

Referral:

- Doctor Family/Friend Other Professional

Online:

- Google/Online Search Social Media Website Ad Signage
 Other: _____

() I authorize the release of any information required in the processing of my health claims

() I authorize my insurance benefits to be paid directly to the health care provider

Patient/Guardian Signature

____/____/____
Date

**CONSENT TO NAME AN AUTHORIZED REPRESENTATIVE TO
PURSUE AN APPEAL OF AN ADVERSE BENEFITS DETERMINATION
INVOLVING MEDICAL JUDGEMENT
&
AUTHORIZATION TO RELEASE INFORMATION RELATING TO THE
APPEAL**

I, ¹ _____, by signing below, agree to representation by the following authorized representative, _____, to act on my behalf in an appeal of an adverse benefits determination involving medical judgement as allowed by the Patient Protection and Affordable Care Act (PPACA) Public Law 111-148, and Section 2719 of the Public Health Services Act (PHS Act) which PPACA has incorporated into the Employment Retirement Income Security Act (ERISA) and the Internal Revenue Code (the Code), making those provisions applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. I also agree to the release of my personal health information to my appointed authorized representative named herein, to Horizon BCBSNJ and its independently contracted Independent Review Organization (IRO) that will review my appeal. My consent to this appointment of this authorized representative and my authorization of release of my personal health information expires 24 months, but I may revoke both sooner.

Signature: _____ Ins. ID#: _____ Date: _____

Relationship to Patient: I am the patient I am a personal representative

¹ If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete this form.



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HIPAA/PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

The Orthopaedic Center is very concerned about the protection of your health information. Federal Law requires all physician offices to have a signed privacy statement on file for every patient. In order to serve you, we must have an existing Privacy Acknowledgement form on file. The law is intended to protect the privacy of your medical records. –Thank you.

I have been given the opportunity to review the Notice of Privacy Practices.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Patient's Personal Representative & Relationship: _____

Any and all situations can be discussed with: _____

In case of emergency, please contact:

Name: _____

Phone Number: _____

[] I do, [] I do not give permission to The Orthopaedic Center to leave detailed messages on my answering machine, mail to my home or fax any information regarding appointments, instructions for surgery, test results, billing and/or insurance issues or other pertinent information.

Fax #: _____

Patient Signature

Date



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FINANCIAL POLICY AND INSURANCE AUTHORIZATION

I authorize Orthopaedic, Sports Medicine and Rehabilitation Center, PA (“OSMRC”) to release to the Social Security Administration and Centers for Medicare & Medicaid Services, its intermediaries or carriers, or to any other insurance company for which I or my dependents or insurance beneficiaries is/are covered insureds, any information, including protected health information, needed for processing of claims for payment for services rendered to me or my dependents or insurance beneficiaries, as applicable. I request that payment of Medicare and/or other third-party insurance company benefits for services rendered to me (or my dependents or insurance beneficiaries, as applicable) be made directly to OSMRC. If my insurance carrier will not assign benefits to OSMRC, then I understand that I am responsible for payment of all charges, regardless of whether or not I am later reimbursed by my insurance plan.

We are providers for some insurance plans and we will bill your insurance company directly. Most plans require co-payments and/or deductibles and co-insurance that are due at the time of service.

If we are not a participating provider with your insurance plan, or you do not have insurance, payment is expected in full at the time of service.

If your visit is a result of a work injury or motor vehicle accident, you must provide us with the following information prior to your visit: insurance carrier, claim number, adjuster’s full name and phone number, and date of accident. If your visit is not authorized by this insurance carrier, you will be fully responsible for service rendered.

I understand that I am responsible for all deductible, co-payment, co-insurance and/or charges for all non-covered services. It is customary to pay for services when rendered unless other arrangements have been made. Acceptable forms of payment are cash, check, Visa, MasterCard, Discover or American Express. There is a \$20 administration fee for any returned check. In the event I fail to pay for services rendered, when payment is due, my account will be turned over to collection.

Please feel free to contact our Billing Office if you have any questions. We are happy to answer your questions or to provide additional information.

I understand and acknowledge the financial policy and insurance authorization terms stated above.

Patient’s Name

Date

Signature (Patient/Guardian)



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CANCELLATION AND NO-SHOW POLICY

Appointments for office visits or procedures that are cancelled with less than 24 hours' notice will be subject to a cancellation fee of \$25.00.

Appointments for office visits or procedures that are missed without advance notice will be subject to a no-show fee of \$50.00.

Please note that these fees are not covered by insurance

To cancel or reschedule an appointment, please contact our office at (732) 741-2313.

Patient Name **DOB**

Patient Signature **Date**



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Consent for the use of Artificial Intelligence (AI)

To assist with medical documentation, our office uses secure artificial intelligence (AI) technology that listens to the conversation during your visit and generates a draft clinical note. This technology helps improve documentation accuracy and allows the physician to focus more attention on patient care. By signing below, you acknowledge and consent to the use of AI-assisted documentation during your visit. You may decline this option at any time.

Patient Name

Date

Patient Signature