

CHART #	LAST NAME		FIRST NAME		M.I.	MARITAL STATUS			
DATE OF BIRTH	AGE	SEX M F	HEIGHT FT: IN:		WEIGHT	S M W D SS#			
ADDRESS						HOME PHONE#			
						CELL #			
SPOUSE'S NAME		PARENT'S NAME IF A MINOR			ADDRESS IF DIFFERENT FROM ABOVE				
PATIENT'S EMPLOYER (FATHER'S IF PATIENT A MINOR)					OCCUPATION				
EMPLOYER'S ADDRESS					WORK PHONE #				
SPOUSE'S EMPLOYER (MOTHER'S IF PATIENT A MINOR)					OCCUPATION				
EMPLOYER'S ADDRESS					WORK #				
EMERGENCY CONTACT:			PRIMARY PHONE #			SECONDARY PHONE #			
REFERRED BY:									
FAMILY MD:			ADDRESS:				PHONE #		
LIST ANY MEDICATIONS & DOSAGES YOU ARE PRESENTLY TAKING:									
1. _____					5. _____				
2. _____					6. _____				
3. _____					7. _____				
4. _____					8. _____				
<b>LIST KNOWN DRUG ALLERGIES:</b> _____									
<b>ARE YOU ALLERGIC TO LATEX?</b>			<b>YES</b>			<b>NO</b>			
LIST KNOWN MEDICAL PROBLEMS/PAST SURGERIES									
1. _____					4. _____				
2. _____					5. _____				
3. _____					6. _____				
ADDITIONAL INFORMATION: _____									
THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY BELIEF									
PATIENT'S SIGNATURE _____						DATE: _____			

NAME \_\_\_\_\_

Date \_\_\_\_\_

*The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you. Do you have a history of:*

- |                                |                |                               |                |
|--------------------------------|----------------|-------------------------------|----------------|
| 1. Unexplained weight loss     | YES ___ NO ___ | 29. Fibromyalgia              | YES ___ NO ___ |
| 2. Fever or chills             | YES ___ NO ___ | 30. Stomach/intestinal ulcers | YES ___ NO ___ |
| 3. Night sweats                | YES ___ NO ___ | 31. Change in bowel habits    | YES ___ NO ___ |
| 4. Skin rashes                 | YES ___ NO ___ | 32. Urinary frequency         | YES ___ NO ___ |
| 5. Head trauma                 | YES ___ NO ___ | 33. Incontinence              | YES ___ NO ___ |
| 6. Frequent headaches          | YES ___ NO ___ | 34. Thyroid problems          | YES ___ NO ___ |
| 7. Double or blurry vision     | YES ___ NO ___ | 35. Diabetes                  | YES ___ NO ___ |
| 8. Hearing loss                | YES ___ NO ___ | 36. Hepatitis                 | YES ___ NO ___ |
| 9. Ringing in ears             | YES ___ NO ___ | 37. Muscle weakness           | YES ___ NO ___ |
| 10. Nasal congestion           | YES ___ NO ___ | 38. Leg swelling              | YES ___ NO ___ |
| 11. Hoarseness                 | YES ___ NO ___ | 39. Varicose veins            | YES ___ NO ___ |
| 12. Sore throat                | YES ___ NO ___ | 40. Blood clots               | YES ___ NO ___ |
| 13. Swollen glands             | YES ___ NO ___ | 41. Anxiety                   | YES ___ NO ___ |
| 14. Breast masses or lumps     | YES ___ NO ___ | 42. Depression                | YES ___ NO ___ |
| 15. Wheezing                   | YES ___ NO ___ | 43. Memory loss               | YES ___ NO ___ |
| 16. Shortness of breath        | YES ___ NO ___ | 44. Hernias                   | YES ___ NO ___ |
| 17. Coughing                   | YES ___ NO ___ | 45. Menstrual problems        | YES ___ NO ___ |
| 18. High blood pressure        | YES ___ NO ___ | 46. Bleeding problems         | YES ___ NO ___ |
| 19. Heart murmur               | YES ___ NO ___ | 47. Unusual post-op bleeding  | YES ___ NO ___ |
| 20. Palpitations               | YES ___ NO ___ | 48. Anesthesia problems       | YES ___ NO ___ |
| 21. Stroke                     | YES ___ NO ___ | 49. Cancer                    | YES ___ NO ___ |
| 22. Chest pain                 | YES ___ NO ___ | 50. Malignant hyperthermia    | YES ___ NO ___ |
| 23. Heartburn                  | YES ___ NO ___ | 51. HIV OR AIDS               | YES ___ NO ___ |
| 24. Heart attacks              | YES ___ NO ___ | 52. Metal in eyes             | YES ___ NO ___ |
| 25. Congestive heart failure   | YES ___ NO ___ | 53. Brain aneurysm clip       | YES ___ NO ___ |
| 26. Pacemaker or defibrillator | YES ___ NO ___ | 54. Cochlear implants         | YES ___ NO ___ |
| 27. Cardiac stents             | YES ___ NO ___ | 55. Sleep apnea               | YES ___ NO ___ |
| 28. Abdominal pain             | YES ___ NO ___ | 56. Asthma                    | YES ___ NO ___ |
57. Do you smoke? \_\_\_\_\_ Have you ever? \_\_\_\_\_ How much? \_\_\_\_\_
58. Do you drink alcohol? \_\_\_\_\_ Have you ever? \_\_\_\_\_ How much? \_\_\_\_\_
59. Recreational drug use? \_\_\_\_\_ Explain \_\_\_\_\_
60. Does any family member suffer from any medical problems? \_\_\_\_\_
61. Does any blood relative have a history of malignant hyperthermia or any other anesthesia Problems? YES \_\_\_ NO \_\_\_

THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY BELIEF.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DOCTOR SIGNATURE

PATIENT'S NAME _____	<b>***IMPORTANT: YOU <u>MUST</u> HAVE A REFERRAL FOR YOUR APPOINTMENT IF REQUIRED BY YOUR INSURANCE. PLEASE CONTACT YOUR PCP***</b>
PRIMARY INSURANCE _____	SECONDARY INSURANCE _____
ADDRESS _____	ADDRESS _____
GROUP # _____	GROUP # _____
ID# _____	ID# _____
SUBSCRIBER _____	SUBSCRIBER _____
SUBSCRIBER'S DATE OF BIRTH _____	SUBSCRIBER'S DATE OF BIRTH _____
IS A REFERRAL REQUIRED? _____	IS A REFERRAL REQUIRED? _____
IS SCHOOL INSURANCE INVOLVED? YES NO	SCHOOL NAME _____
DID YOU FILE A CLAIM WITH THE SCHOOL? YES NO	

**\*\*\*IF THIS VISIT IS COVERED BY WORKMEN'S COMPENSATION OR MOTOR VEHICLE ACCIDENT INSURANCE AND WE WERE NOT INFORMED OF THIS WHEN THE APPOINTMENT WAS MADE, PLEASE CONTACT US IMMEDIATELY AT 610-375-4949**

WAS THIS AN AUTO ACCIDENT: YES NO      DATE OF ACCIDENT: \_\_\_\_\_

NAME OF INSURANCE COMPANY \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

PHONE: \_\_\_\_\_ CLAIM # \_\_\_\_\_

ATTORNEY \_\_\_\_\_ PHONE # \_\_\_\_\_

WAS THIS A WORK INJURY? YES NO      DATE OF ACCIDENT: \_\_\_\_\_

WERE YOU INJURED ON THE JOB? YES NO      WAS THE ACCIDENT REPORTED? YES NO

INSURANCE CARRIER: \_\_\_\_\_

CONTACT PERSON \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CLAIM # \_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT: I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS INCLUDING AUTO, MEDICARE, PRIVATE, WORKER'S COMPENATION AND OTHER MEDICAL HEALTH PLANS TO WHICH I AM ENTITLED TO BERKSHIRE ORTHOPEDIC ASSOCIATION. I AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THESE BENEFITS AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. THE ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING AND A PHOTO COPY IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.**

SIGNATURE OF PATIENT (GUARDIAN IF PATIENT IS A MINOR) \_\_\_\_\_ DATE \_\_\_\_\_

**BERKSHIRE ORTHOPEDICS , LLC FINANCIAL POLICIES**

Regardless of your insurance coverage, you are always responsible for making sure your bill is paid promptly and in full. This office cannot accept responsibility for collecting your insurance claim or negotiating a settlement on a claim. Patients should remember that professional services are rendered and charged to the patient, not to the insurance company. Charges are never contingent upon the outcome of pending lawsuits, insurance disputes, or reimbursement from insurance companies. If your account has an outstanding balance, you will receive a statement each month. Monthly payments are required on accounts.

**COPAYMENTS, COINSURANCES, AND DEDUCTIBLES**

The patient is expected to present an insurance card at each visit. All co-payments, coinsurances, deductibles and past-due balances are due and payable at check-in. If you cannot pay, you will be asked to reschedule your appointment.

**SELF PAY ACCOUNTS**

Self-pay accounts are patients who are covered by insurance plans that the office does not participate in, patients without an insurance card on file, patients without referrals or unverified accident cases. It is expected that payment is required at the time of all services including surgeries. Office charges will be collected at check-in.

**NON-PARTICIPATING INSURANCE PLANS**

The insurance will be billed as a non-assigned claim as a courtesy to the patient, with the patient paying the office the amount in full. The insurance company will reimburse the patient on non-assigned claims.

**PATIENT REFUNDS**

The following criteria must be met prior to issuing a patient refund: the patient does not have any scheduled appointments, there are no out-standing insurance claims on the patient's account, and there are no out-standing patient balances on the account.

**REFERRALS**

If your insurance has designated a primary care physician (PCP), you are required to have prior authorization from your PCP prior to your office visit. If this authorization is not provided, you will be asked to reschedule your appointment or pay for the visit at the time of service

**CHILD CUSTODY CASES**

The parent with primary custody is usually the parent with whom the child lives and who usually brings the child to the office for care. The custodial parent is responsible to pay at the time of the service. If the non-custodial parent carries the insurance on the child the office will bill that insurance company. The office does not get involved with divorce specifics. It is the parent's obligation to work out an agreement themselves or through the court system.

**WORKER'S COMPENSATION AND AUTOMOBILE ACCIDENT CASES**

We will file your claim to your insurance carrier. All claims must be verified prior to service being rendered. If a claim is not verified, you will be considered a self-pay and payment will be collected at check-in. You will be responsible for your bill if your claim is denied for any reason.

**APPOINTMENT CANCELLATION POLICY**

We understand if you can't keep an appointment but please call us to notify us. There may be a \$35 charge to those who do not call to cancel an appointment.

**PAST-DUE ACCOUNTS**

Any time a payment is not received during the last 30 days, your account is considered to be past due. If you are having trouble paying your bill, we can arrange a payment plan for you. Accounts more than 60 days past due will be turned over to collection. Unpaid collection accounts could be reported to the credit bureau.

**AGREEMENT TO PAY**

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, attorney fees, and/or court costs, if such are necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Pennsylvania, and any other State.

**CONSENT TO CONTACT**

You agree, in order for us to service your account or to collect monies you may owe, BOA and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices as applicable.

**RECORDS RELEASE**

I authorize Berkshire Orthopedics, LLC., to release all information necessary to secure payment. This would include all auto, work comp., school insurance and all other insurances. The assignment will remain in effect until revoked by me in writing and a photocopy is to be considered as valid as the original.

This financial policy helps the office provide quality care to our valued patients. If you have any questions please feel free to contact us.

I \_\_\_\_\_ give permission for BOA to give medical treatment.

I have the right to refuse any procedure or treatment.

I have the right to discuss all medical treatments with my clinician.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

**Berkshire Orthopedics LLC**

**HIPAA Compliance Patient Consent Form / Notice of Privacy Practices**

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's right section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. Our HIPAA notice is posted in the waiting room and will provide you a copy upon your request.

The terms of this notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information (PHI) is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your PHI and acknowledge that you have been offered a copy of Notice of Privacy Practices. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that: PHI may be disclosed or used for treatment, payment or healthcare operations. The practice reserves the right to change the privacy policy as allowed by law. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.

**Please read the selections and check all that apply:**

\_\_\_\_\_ Staff may leave messages on answering machines (i.e. appt reminders, test results, medications, and other treatments)

\_\_\_\_\_ cell phone \_\_\_\_\_ home phone \_\_\_\_\_ work phone

**May we discuss your medical condition with any family member / friend? YES NO**

**If yes, Please list name/relationship and phone number below (list additional names on back)**

**I authorize the physician and staff to discuss my health information with the following person(s):**

1. \_\_\_\_\_

2. \_\_\_\_\_

**This consent was signed by: (PLEASE PRINT NAME) \_\_\_\_\_**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**