Orthopedic Associates
OF DUTCHESS COUNTY

| PATIENT INFORMATION | |
|---|---|
| **Name:** | **Date of Birth:** |
| **Address One:** | **Social Security #:** |
| **Address Two:** | **Sex:** |
| **City:** | **Patient Age:** |
| **State:** **Zip:** | **Employer:** |
| **Home Phone#:** | **Email Address:** |
| **Work Phone#:** | **Emergency Contact:** |
| **Cell Phone#:** | **Emergency Phone#:** |
| **PCP:** | **Emergency Contact DOB:** |
| **GUARANTOR INFORMATION** | |
| **Name:** | **Date of Birth:** |
| **Address One:** | **Social Security#:** |
| **Address Two:** | **Home Phone#:** |
| **City:** | **Work Phone#:** |
| **State:** **Zip:** | **Cell Phone#:** |
| **INSURANCE INFORMATION** | |
| **Primary Insurance:** | **Secondary Insurance:** |
| **ID#:** | **ID#:** |
| **Group #:** | **Group #:** |
| **Copay:** | **Copay:** |
| **Subscriber Name:** | **Subscriber Name:** |

**Work related injury? Y N Auto Accident? Y N**

*** If you have answered yes please provide the workers compensation insurance or No Fault (auto) insurance in addition to your private medical insurance ***

****Attention**** **Please Read And Sign:**

**I agree that Orthopedic Associates of Dutchess County, P.C. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. ____ ____Initials _____ Date**

**Pharmacy Name:_____City/Town:_____Ph#_____**

**Your patient information may be used to contact you by telephone/mail for the purpose of treatment, payment or health care operations. If you have any restrictions for communication with you please let us know on this line. ___ _____**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices Policy. I have read (or have the opportunity to read if I choose) and understand the notices.

_____

Patient Name (Please Print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

**Patient Financial Policy**

**Co-pays, Coinsurances, and Deductibles:**

The patient is expected to present a valid insurance card at each visit. All payments and past due balances are due and payable at the time of service. Auto pay is available via credit card to resolve balances.

- Deductible policy: If you have not met your deductible for the calendar year OADC requires a down payment toward your estimated cost of your visit. New consultations require $200 and all follow up exams require $100 at check in. Once your insurance has processed your claim the balance due will be sent to you for payment.

**Self-pay accounts:**

Self-pay accounts are:

- Patients without valid insurance coverage at time of service.
- Expected to pay for all services at the time of service. Auto pay is available via credit card to resolve balances.

**Extended Payment Arrangements:**

OADC reserves the right to add a service charge or interest to any extended payments. Patients who fail to make a monthly payment will be sent to a collection agency and may be terminated from the practice. Balances under $500 are due at the time of service; a monthly payment plan will not be set. **All payment agreements must be made in writing.**

The policy for balances:

- In excess of $500.00: Patient may make a monthly payment plan with our billing department. A down payment of 50% is expected at the time of service. The total balance must be resolved within 90 days. Auto pay is available via credit card.
- In excess of $1,000.00: Patient may make a monthly payment plan with our billing department. A down payment of 50% is expected at the time of service. The total balance must be resolved within 180 days. Auto pay is available via credit card.
- In excess of $5,000.00: A payment of $500.00 is due at the time of service. The total balance must be resolved within one year of the date of service. Auto pay is available via credit card.

**Durable Medical Equipment (DME):**

All durable medical equipment is to be paid in full at the time of service.

**Non-participating Insurance Plans:**

The financial obligations of patients who are insured by carriers that the practice does not participate with are the patients' responsibility. The insurance company will be billed as a non-assigned claim as a courtesy to the patient with the patient paying the practice the amount in full. The insurance company will reimburse the patient on non-assigned claims. *For surgical procedures please ask to speak to a billing representative prior to the procedure. If the practice receives payment for a non-assigned claim, the patient will receive a refund.

**Child Custody Cases:**

The parent with primary custody is usually the parent whom the child lives and usually brings the child to the practice for care. The custodial parent is responsible for payment at the time of service as per the terms of your insurance. If the non-custodial parent carries the insurance on the child, the office will bill that insurance company. The practice does not get involved with divorce specifics, e.g., one parent pays 80% and the other pays 20%. It is the parents obligation to work out an agreement themselves or through the court system.

**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 authorization is not provided, you will be asked to either reschedule your appointment or pay for the visit at the time of service.

**AUTHORIZATION FOR PAYMENT**

I authorize the release of any medical information necessary to process insurance claims (including HIV/AIDS, Drug and Alcohol abuse, and mental illness) and the release of information back to my physician. I also authorize payment of medical benefits to ORTHOPEDIC ASSOCIATES OF DUTCHESS COUNTY, P.C. for services rendered. In the event that my medical insurance does not pay for services rendered, I agree to pay Orthopedic Associates of Dutchess County, P.C. for these services.

**The patient or legal guardian is responsible for payment of services.**

**********Signed**_____ **Date**_____**********

Signature of Patient/Legal Guardian if patient is a minor

**********MEDICARE BILLING WAIVER**********

I request that payment of authorized MEDICARE benefits be made to me or on my behalf to ORTHOPEDIC ASSOCIATES OF DUTCHESS COUNTY (Drs. Gary Fink, David Dimarco, William Barrick, Russell Tigges, Lawrence Kusior, Sasha Ristic, Michael Schweppe, Wen Shen, Richard Perkins, Carl Barbera, William Colman, Andrew Stewart, Stephen Maurer, Mark Aierstok, Frank Lombardo, John McLaughlin, Kenneth Rauschenbach, Nicholas Renaldo, Donna Flynn, Richard Dentico, Patrick Messerschmitt; Richard Gennaro, Faguna Patel, Stephen Lebitsch, NP, Jennilyn Whittam, NP, Physician Assistants Warren Sheprow, Kathleen Hefferon, Theresa Skelly, Daniel Caputo, and Sijo Padannamackal; Physical Therapists Keith Claire, Charles Hargreaves, Tamara Claire, James Gualtieri, Christine Poole and Georgina Lerma; Occupational Therapists Christina McGrath, Carol Dollard, Heather Kelly, Lorraine Gogreve and Deana Forlenza) for any services furnished to me by those physicians/providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent to any information needed to determine these benefits or the benefits payable for related services.

**********Signed**_____ **Date**_____**********

Medication Refill Policies

For your safety, we have established policies regarding medication refills. Please review them carefully.

- **Please plan ahead and request your refill before your prescription has run out or expired.** Our medication refill policy allows up to three days (72 hours) to process a refill request.

- **Medication will not be refilled after hours.** Messages left after 4:30pm daily will be sent to the appropriate doctor on the next business day. Refills will not be granted on weekends.

- **Requests for medication should be left with the triage department or submitted through the Patient Portal on our website**. When leaving a message, please leave your name, date of birth, phone number, drug allergies, and the name and phone number of your pharmacy. Please also leave the name and dosage (strength) of the medication.

- Someone from our triage department will call you the same business day to review the information before sending your request to the doctor. If you have not received a call **after one business day**, you may call again. You will then receive a call from someone on our clinical staff with the outcome of your request.

- If you have not been seen during the last six months, please call the office to schedule an appointment. Again, this is for your safety. Your medical condition(s) can change significantly in that period of time and we need to have the most up-to-date information. Refills will not be granted in you have not been seen during this time.

- While our team of providers can frequently assist in the care of all patients, requests for narcotic (pain) medication may have to wait for your treating physician. This is to protect the health and safety of our patients.

- **Due to legal restrictions, we cannot replace a prescription for narcotic medications that have been lost or stolen.**

- Written prescriptions must be picked up in the office where the doctor is working that day or in the Poughkeepsie office, by request. **Narcotic** p**rescriptions can no longer be called in to a pharmacy.** If you are unable to pick up the prescription yourself, you may send an appropriate adult (18 or older) with the following: 1) Photo ID of themselves; and 2) A signed note from you giving them permission to pick up the prescription.

- Beginning on August 27th, 2013, Orthopedic Associates will participate with the **New York State I-STOP Program** (Internet System for Tracking Over-Prescribing Act). All narcotic prescriptions will be entered into the database to report and track controlled substances.

- If you feel that your circumstances or symptoms are an emergency, we encourage you to go to your nearest emergency room.

On behalf of all of us at Orthopedic Associates, thank you for trusting us to care for all of your orthopedic needs.

_____
Patient Name (Please Print)

Patient Signature:_____Date:_____