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NORTHWEST OKLAHOMA ORTHOPAEDIC CLINIC, P.C.

900 West Cherokee, Enid, OK 73701

PATIENT REGISTRATION
PLEASE PRINT AND COMPLETE ALL INFORMATION

FOR OFFICE USE ONLY
Chart No: _____
Doctor No: _____
Account Type: _____

Appointment Date: _____ Referred By: _____

PATIENT INFORMATION

FULL LEGAL NAME _____ _____ _____
Last First MI Age Birth Date

Mailing Address: _____
Street City State Zip Code

Mobile Phone _____ Home Phone _____ Work Phone _____ Ext ____

Patient's SSN: _____ Gender (Circle One) M F Employer _____

Current Marital Status (Circle One) SINGLE MARRIED WIDOWED DIVORCED SEPARATED

EMail Address *(legibility is very important)* _____

Spouse's Name _____ Spouse's Birth Date _____ Spouse's SSN:_____

Spouse's Employer _____ Spouse's Phone_____

PHARMACY *(Must have Name - Address - Phone of your preferred pharmacy)*

Name _____ Address _____ Phone _____

NEAREST RELATIVE OR FRIEND TO NOTIFY IN AN EMERGENCY

Name _____ Relationship _____ Phone _____

IF PATIENT IS A MINOR, PLEASE FILL OUT THE INFORMATION BELOW

Father's Name _____
Address (if different) _____
Phone _____ DOB _____
Employer _____
SSN _____

Mother's Name _____
Address (if different) _____
Phone _____ DOB _____
Employer _____
SSN _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The undersigned hereby authorizes Northwest Oklahoma Orthopaedic Clinic, P.C. (the "CLINIC") to at any time release any insurance company or companies, the Social Security Administration, the Department of Public Welfare, the Health Care Financing Administration, their intermediaries or carriers or any other third party payer's, and all medical information contained in my records at the Clinic, whether from a third party source of the CLINIC, or not (the "information") and as may be necessary for the completion a claims or pursuant to my request on behalf of myself. Also, the undersigned authorizes the CLINIC to release such information to my attorney, upon my written request. I hereby authorize the CLINIC (but understand that the CLINIC is not responsible to do so) to submit the claims to any third party payers on my behalf. In consideration of the services rendered, I also assign to the CLINIC payments from an insurance carrier or any other person or party for medical services rendered to myself or my dependence and agree to pay to CLINIC any such proceeds that I might receive. I understand that I am responsible to pay for any amount not covered by third party payer. A photographic copy of these assignments authorized hereunder shall be as valid as the original. I further agree that I will pay for the costs of reproduction of my medical information submitted by the CLINIC under the terms of this authorization.

SIGNATURE :_____**DATE** _____

The undersigned further acknowledges the following:

1. INSURANCE requirements are the patient's responsibility. Some or all services may not be covered. The patient is ultimately responsible for payment in full. As a courtesy, the CLINIC and third-party contractors verify benefits with the insurance company. If the CLINIC does not participate in a plan the patient is considered "Self-Pay" and payment will be due in full at each visit. The CLINIC may utilize an outside, third-party, service for management and handling of insurance eligibility, verification and collections.

2. REFERRALS are the patient's responsibility. The patient must obtain the appropriate authorization required to be seen by a specialist. A referral does not guarantee insurance coverage. The patient should contact their insurance company for any coverage questions.

3. INSURANCE VERIFICATION must be up to date and current. The CLINIC *must* obtain a copy of driver's license and current valid insurance to provide proof of insurance.

4. DISABILITY/RAILROAD FORMS: The CLINIC is not a party to any contracts between the patient and their disability insurer. The average completion time for a disability form is 7-10 business days. Administrative fees may be required prior to the completion of any form for the services of form completion, faxing, copying, postage and telephone calls to and from your insurance company. An addressed envelope or the fax number where the completed form should be sent must be provided by the patient. The completed original form will not be sent only to the insurance company. A separate Patient Disability Claim Form which establishes the fees and documents the process may require completion.

5. MEDICAL RECORDS will be sent directly to another provider, at the provider's request, participating in a patient's medical care at no charge. If the patient, or other party, requires a copy, fees are $10 for the first 20 page faces and $.50 per page face in excess of 20 page faces. The CLINIC requires 15 business days in which to copy records before making them available for patients to pick up. The 15 business days will commence after payment has been received and after the CLINIC has obtained a signed form authorizing the release of records.

6. FINANCIAL:
    a. All payments and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service.
    b. The patient is responsible for any balance remaining after insurance has adjudicated (processed) a claim. The CLINIC will reimburse any overpaid funds after all claims have been processed.
    c. Administrative labor beyond direct patient care is incurred with delinquent debts. A delinquent debt is defined as any payment balance over 90 days past insurance adjudication or final processing or any action constituting a breach of payment. Delinquent debt may be turned over to a collection agency and may result in the patient's termination from the CLINIC's practice unless otherwise negotiated. Should collection of delinquent debt become necessary, patient agrees to pay late fees, rebilling fees, collection agency fees, and all legal fees of collection with or without suit, including attorney fees and court costs. All additional cost and/or fees will be added to the patient's outstanding balance.
    d. Late fees for balances over 90 days past insurance adjudication (final processing) are $5 for balances less than $100; $10 for balances between $100 and $250; and $25 for balances over $250.
    e. If financial hardships arise, the patient must contact the CLINIC at (580) 233-6707 to discuss payment options. We understand some patients may have limited means to pay their bill. To offer consideration of decreasing financial liability to the CLINIC, the patient may be required to submit up to two years of tax returns, pay stubs, bank statements or other means of financial hardship verification.
    f. Returned or cancelled or bad checks will incur a $40 fee for any checks returned for insufficient funds, plus any bank fees incurred. A stop payment will constitute a breach of payment and subject to a $40 service fee and immediate collections action. These actions are in addition to any fees incurred by the patient's indebtedness. All bad checks written to this office are subject to collections and full cooperation with the District Attorney.
    g. Any amounts due from the patient is considered a legitimate and lawful debts, obligations, and the CLINIC may use any lawful means to collect. The CLINIC may refuse to provide service to a patient who fails to pay any amounts due.

7. DIVORCED/SEPARATED/ESTRANGED PARENTS or GUARDIANS of PATIENTS: The CLINIC will not act as intermediary nor mediator for payment from absent responsible parties. The adult signatory below accepts responsibility for payments and communication of treatment plans to absent parties. If a divorce decree requires other parties pay all or part of the bill, it is the responsibility of the authorizing adult to collect from that party. The CLINIC is not a party to any divorce decree. The CLINIC will not bill another individual or estranged spouse for payment. Copayment is due at the time services are rendered.

8. HIPAA: I acknowledge that I have been provided Northwest Oklahoma Orthopaedic Clinic, PC HIPAA Privacy Notice.

9. REQUESTED RESTRICTIONS: The patient will notify the CLINIC in writing of any requested restrictions on disclosure of health information.

10. CHANGES TO MEDICAL RECORD: Any request to change the medical record must be submitted in writing, with specificity. Any request to change the medical record, verbal or written, will be made a permanent part of the medical chart.

11. PATIENT CONTACT: The CLINIC is authorized to utilize my address, phone number and/or email address that I have provided to contact me about my care, treatment, insurance, or payments due for services rendered, including leaving voicemail information.

SIGNATURE _____ **DATE** _____

The undersigned further acknowledges the following:

Northwest Oklahoma Orthopaedic Clinic, PC reserves the right to dismiss any patient from practice who fails to meet the requirements of this policy or who refuses to sign this agreement. By signing below I understand and agree to the terms of this office's policy.

SIGNATURE _____ **DATE** _____