Centers for Advanced Orthopaedics, LLC

Robinwood Division

HIPAA Compliant Information Form

For Office Use Only
Chart # _____
Doctor _____
Updated _____
Initials _____

Date _____

PATIENT INFORMATION

Please PRINT clearly

Name (Last): _____ (First): _____ (MI): _____

Sex: ___ M ___ F Date of Birth: _____ Age: ___ State/Country of Birth _____ SS #: _____

Marital Status: S___ M___ Other _____ Email Address: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Employer Address: _____

Family Doctor (Full Name): _____ Referring Doctor (Full Name): _____

Pharmacy: _____ Address: _____ Phone: _____

Part of Body to be Examined: _____ Date of Accident/Onset of Illness: _____

Emergency contact: *Please list an alternate person to whom we may release medical information if you are unable to be reached.*

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

INFORMATION REQUIRED BY THE FEDERAL GOVERNMENT

The Center for Medicare & Medicaid Services requires all providers to request the following information.

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unreported/Refused to Report

Race

- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ More than 1 race
- ☐ Unreported/Refused to Report

Preferred Language

- ☐ English
- ☐ Spanish
- ☐ Other _____
- ☐ Undefined
- ☐ American Sign Language
- ☐ Chinese
- ☐ Russian

PARENT / LEGAL GUARDIAN *(For children under age 18)*

Name (Last): _____ (First): _____ (MI): _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security #: _____ Date of Birth: _____

Legal Custodian: _____ Relationship to Patient: _____

Email: _____

Please provide us with a copy of legal documentation

The person(s) listed above are authorized to receive medical information for this patient: YES or NO (Please Circle)

*****Note: The parent who brings a child to the office for medical treatment is responsible AT THE TIME OF SERVICE for co-payment, deductibles, and account balances. If our provider is not a participating provider with your insurance company, payment in full is required at the time of service.**

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POWER OF ATTORNEY *(For Adults) (If Applicable)*

Name (Last): _____ (First): _____ (MI): _____

Street Address:_____ City:_____ State:____ Zip:_____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Relationship to patient:_____ ***Please provide us with a copy of legal documentation***

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Effective Date: _____

Member ID: _____ Group Number:_____

Policy Holder Name: _____ Sex: ___M ___F Policy Holder Date of Birth: _____
(First) (MI) (Last)

Policy Holder SS #: _____ Patient's Relationship to Policy Holder:_____

Policy Holder Employer: _____Employer's Phone #:_____

Employer's Address:_____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Effective Date: _____

Member ID: _____ Group Number:_____

Policy Holder Name: _____ Sex: ___M ___F Policy Holder Date of Birth: _____
(First) (MI) (Last)

Policy Holder SS #: _____ Patient's Relationship to Policy Holder:_____

Policy Holder Employer: _____Employer's Phone #:_____

Employer's Address:_____

***Please inform us if you have a third insurance.**

If this is Workers' Comp. or accident related, please inform us and provide us with the proper paperwork.

Date of Injury: _____Insurance Company:_____

Contact Person: _____Phone Number:_____

Claim Number: _____

I certify that the information on this form is current and accurate to the best of my knowledge.

(SEAL)_____ _____ _____

Signature of Patient/Parent/Guardian | Relationship | Date

The Centers for Advanced Orthopaedics

Robinwood Division

Name: _____ Chart: _____

Date: _____ Date of Birth: _____

Assignment of Insurance Benefits:

As the patient whose name appears below, I hereby authorize Centers for Advanced Orthopaedics, Robinwood Division to file on my behalf for payment and/or appeal letters of any medical benefits arising out of any policy of insurance covering me and hereby assign the benefits to Centers for Advanced Orthopaedics, Robinwood Division for application on the patient's bill. I certify that the information reported with regard to my insurance coverage is accurate and complete and further authorize the release of any necessary information, including medical information, for this or any related claim of medical benefits. I permit a photocopy of this authorization be used in place of the original. I understand that I am liable for payment to Centers for Advanced Orthopaedics, Robinwood Division, all co insurance, co-pays, and deductibles as required by my insurance policy and participating agreements (if any) between the insurance carrier and Centers for Advanced Orthopaedics, Robinwood Division. Further, I will be responsible for charges not covered by my insurance.

Financial Responsibility:

Payment is requested at the time services are rendered. **All co-pays will be expected at time of service.** If expensive or extended treatment is anticipated, arrangements may be made for a payment plan. All professional services rendered are charged to the patient and the patient (or guardian) is responsible for all fees regardless of insurance carrier. Payments for charges which are the patient's responsibility are to be paid within 30 days. The patient and/or guarantor signing below accept responsibility for payment. Should the patient's account be assigned to a collection agency, you will be responsible and agree to pay 33 1/3% of the total balance in collection agency fees, court cost and attorney fees. Our staff will gladly assist you with any aspect of this policy.

I, parent or legal guardian, do hereby authorize Centers for Advanced Orthopaedics, Robinwood Division to treat _____ being _____ years of age and a minor. I understand that I am fully responsible for this minor's medical charges and agree to pay all charges for services rendered by the above named medical practice.

Centers for Advanced Orthopaedics, Robinwood Division's "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office's Notice of Privacy Practices by signing below:

In order to serve our patients better, we have instituted a no show policy. The following fees will be added to your account and must be paid in full before any further appointments can be made. **Surgery at any location $250, nerve conduction study $100, injection done at a surgical facility $100, pre-op history and physical appointment $50, No show in the office $25.00.**

_____ _____

Patient Signature **Date** **Parent/legal guardian or POA** **Date**

_____ _____

Printed Name **Relationship to patient**

PLEASE TURN OVER

Centers for Advanced Orthopaedics,

LLC Robinwood Division

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Doctor _____
Update: _____
Initials _____

PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED HEALTH INFORMATION TO BE USED AND/OR DISCLOSED

Name or specifically identify these persons and/or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

Name of Authorized Person or Entity	**Relationship**	**Phone #**
Name of Authorized Person or Entity	**Relationship**	**Phone #**

AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICE MAIL

Robinwood Orthopaedic Specialty Center's physicians and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our offices leave messages on communication devices provided by our patients. Due to the federally mandated HIPAA Privacy Rule we must obtain your authorization to continue this mode of communication. Protected Health care Information that we may possibly disclose on your home, work, or cell phone would include, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, surgical posting/scheduling information and billing-related information.

Please select one option below:

_____ (Initial) Yes, I agree to allow Robinwood Orthopaedic Specialty Center's physicians and healthcare staff to leave messages that include Protected Healthcare Information on all three communication devices: **home, work and cell phone**.

_____ (Initial) I agree to allow Robinwood Orthopaedic Specialty Center's physicians and healthcare staff to leave messages that include Protected Healthcare Information on the following. **Please initial next to the applicable communication device(s):**

_____ **Home Number** _____ **Work Number** _____ **Cell Number**

_____ (Initial) No, I do not agree to allow Robinwood Orthopaedic Specialty Center's physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work or cell phone.

_____ Patient Name (Please Print)

_____ Patient Signature

_____ Patient Date of Birth (Important)

_____ Date