UPPER BUCKS ORTHOPAEDICS AT GRAND VIEW HEALTH

When seeking medical treatment, patients for their own well being, not only need to understand their medical condition, but also their financial liability. We are here to aid in your financial claim processing, but ultimately it is the patient's responsibility for outstanding balances.

We thank you in advance for taking the time to review these policies and appreciate your compliance and cooperation.

Please feel free to discuss any concerns or questions you may have with our billing staff.

Things to bring with you to your visit

- Health Insurance Card (will be checked at every visit)
- Drivers License
- Method of payment – for your convenience we accept cash, check, debit and credit card. The credit cards we accept are Visa, Master Card and Discover.

Patient out of pocket expenses

- We are obligated to collect the co-pay at the time of your visit. This is a requirement of your insurance plan. Remember to stop at front desk each visit to pay your co-pay.
- Any co-pays not paid at time of service are subject to a $10 billing fee.
- All payments are due at the time of service.
- For self pay, deductible, or other large amounts we offer Care Credit, credit cards or monthly payment plans for your convenience.

Patient Responsibility

- Minor patients: For all services rendered to minor patients, we will look to the accompanying adult for payment.
- It is the patient's responsibility to provide UBOA with the most up to date insurance information.
- It is also the patient's responsibility to verify benefits of their policy
- We are not liable for any misquoted benefit information. You are fully responsible for verifying benefits of your policy.

Full Pay

- We offer a reasonable discount for cash pay/fee for service patients who have no health insurance coverage.
- Payment in full is expected at the time of visit unless prior arrangements have been made with the billing department.
- You will be asked to sign a waiver stating that you have no health insurance coverage and will not be filing a claim with any health insurance carrier or third party payer.
- We understand you may be applying for Medical Assistance to help defray these costs. We will expect monthly payments on your account until you can prove you have been enrolled for coverage with MA. Any monies collected for services rendered after your eligibility date will be refunded. You are responsible for informing us when you become active with MA.

HMO plans

- A valid referral is required at the time of service prior to being seen. This is a requirement of your insurance plan.
- If you do not have a referral at the time of your visit, you will be asked to sign a waiver stating you are aware that you are responsible for payment upon check out on that day.
- If a valid referral is obtained and your insurance company reimburses the correct amount, you will be refunded all monies due.

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Litigation cases

- We do not get involved with any litigation accounts, disputed work comp cases, divorce decrees or auto accidents. You will be 100% responsible for any balances due.

Returned checks

- There is a $25 fee for all returned checks.
- Payments after a returned check are cash or credit card only.

Credit card payment plan policy

- You will be asked to review and sign our credit card on file policy and authorization form.
- Your credit card will be billed for fees not covered by your insurance and according to the agreed upon monthly payment plan.

Outstanding balances/Collections

- Prior to providing additional services to you, payment in full of total outstanding balances will be required.
- Patients with two or more delinquent accounts, or delinquent accounts greater than $500, will be discharged from the practice.
- Billing statements will be mailed for balances that are denied or deemed patient responsibility. Payment is expected within three weeks of the billing date. If no payment has been received a second statement will be sent. In the event a third statement is required, additional collection steps will be taken. Your failure to make payment may result in your account being turned over to a third party collection agency who reports to the credit bureau.

Refunds

- Refunds are issued to the appropriate party. Patient refunds will not be processed until all active or past due charges are paid in full. Refunds of less than $5 will not be issued.

I have read and understand Upper Bucks Orthopaedics' financial policy.

_____ _____ _____

Printed Name Patient name if minor (DOB of Patient)

_____ _____

Signature Date

Relationship to patient: ____ Self ____ Parent ____ Other _____

Upper Bucks Orthopaedics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Upper Bucks Orthopaedics at Grand View Health

HIPAA Acknowledgement Form

I, _____, DOB: _____, understand that as part of my health care, UBO at GVH originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I further understand that UBO reserves the right to change their notice and practices in accordance with Section 164.520 and 164.506 of the Code of Federal Regulations.

Please list the individual(s) with whom we may discuss your medical information:

_____

_____

Please list the individual(s) with whom we may discuss your billing statement/payment arrangement:

_____

Upper Bucks Orthopaedics reserves the right to leave messages on the home/cell telephone numbers that you have filled out on your registration form unless you specify otherwise.

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

_____ _____

Signature of Patient (or Patient's Legal Representative) Date

Personal Representative Information (if applicable)

_____

Name of Personal Representative

_____

Relationship to Patient (or other authority)

Upper Bucks Orthopaedics at Grand View Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Upper Bucks Orthopaedics at Grand View Health **Date:_____**

Name: _____DOB:_____Height:_____Weight:_____

Referring Physician: _____ Dominant Hand: ☐ Right ☐ Left (check one)

Please check the reason for **today's appointment**: Include Right (R), Left (L) or Both (B) where applicable

Hip ☐ L ☐ R ☐ B	**Groin** ☐ L ☐ R ☐ B	**Pelvis** ☐
Thigh ☐ L ☐ R ☐ B	**Shin** ☐ L ☐ R ☐ B	**Finger**: _____
Shoulder ☐ L ☐ R ☐ B	**Clavicle** ☐ L ☐ R ☐ B	**Upper Arm** ☐ L ☐ R ☐ B
Elbow ☐ L ☐ R ☐ B	**Forearm** ☐ L ☐ R ☐ B	**Toe**: _____
Hand ☐ L ☐ R ☐ B	**Wrist** ☐ L ☐ R ☐ B	**Heel** ☐ L ☐ R ☐ B
Knee ☐ L ☐ R ☐ B	**Calf** ☐ L ☐ R ☐ B	**Back** ☐ Upper ☐ Middle ☐ Lower
Ankle ☐ L ☐ R ☐ B	**Foot** ☐ L ☐ R ☐ B	**Neck** ☐

Other: _____

Date of Injury/When Symptoms Started: _____ Where injury occurred: _____
Work Related? ☐ Yes ☐ No Motor Vehicle Accident? ☐ Yes ☐ No
Describe, **in DETAIL**, injury or reason for visit: _____
_____

Family History: Check any of the following diseases that are in your immediate family:

Mother	Father	Brother	Sister	Son	Daughter
☐ None	☐ None	☐ None	☐ None	☐ None	☐ None
☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer
☐ Bone Cancer	☐ Bone Cancer	☐ Bone Cancer	☐ Bone Cancer	☐ Bone Cancer	☐ Bone Cancer
☐ Lung Disease	☐ Lung Disease	☐ Lung Disease	☐ Lung Disease	☐ Lung Disease	☐ Lung Disease
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Rheumatoid Arthritis	☐ Rheumatoid Arthritis	☐ Rheumatoid Arthritis	☐ Rheumatoid Arthritis	☐ Rheumatoid Arthritis	☐ Rheumatoid Arthritis
☐ Heart Disease	☐ Heart Disease	☐ Heart Disease	☐ Heart Disease	☐ Heart Disease	☐ Heart Disease
☐ Anesthesia Complications	☐ Anesthesia Complications	☐ Anesthesia Complications	☐ Anesthesia Complications	☐ Anesthesia Complications	☐ Anesthesia Complications

Social History: Check one that applies

Marital status:	☐ Married	☐ Single	☐ Divorced	☐ Separated	☐ Widowed
Employment:	☐ Student	☐ Unemployed	☐ Employed	☐ Retired	☐ Disabled
Tobacco History:	☐ Never a Smoker	☐ Daily Smoker	☐ Occasional Smoker	☐ Former Smoker	
Alcohol History:	☐ Never Drinks	☐ Currently drinks	☐ Drank in past only		

Past Surgical History: Please check all prior surgeries you have had and specify type

☐ NO PRIOR SURGERIES	☐ Tonsillectomy/adenoidectomy	☐ Breast: _____
☐ AICD/Pacemaker	☐ Other Heart: _____	☐ Appendectomy
☐ Angioplasty/stent	☐ Vascular: _____	☐ C-section
☐ Hand surgery: _____	☐ Shoulder: _____	☐ Wisdom teeth
☐ Knee surgery: _____	☐ Spine: _____	☐ Gallbladder
☐ Foot: _____	☐ Eye: _____	☐ Hernia repair
☐ Ankle: _____	☐ Hip: _____	☐ Hysterectomy

☐ Other Surgeries: _____

ALLERGIES: Please list all Medication allergies and the reaction to that medication(s) ☐ **No Known Allergies**

MEDICATION	***REACTION***
_____	_____
_____	_____

Other Allergies (foods, environmental, Latex, etc.): _____

Patient Name/DOB: _____

Have you had the **Flu shot** (Influenza vaccine) ☐ No ☐ Yes Approximate Date: _____

Have you had the **Pneumonia shot** (Pneumococcal vaccine)? ☐ No ☐ Yes Approximate Date: _____

Past Medical History: Please check all that apply:

- ☐ History of MRSA
- ☐ Diabetes
- ☐ Bleeding Disorder
- ☐ Pulmonary Embolism
- ☐ DVT (blood clot in leg)
- ☐ Thyroid Condition
- ☐ HIV/AIDS
- ☐ Leukemia/Lymphoma
- ☐ Sleep Apnea/CPAP
- ☐ Hiatal Hernia/Reflux
- ☐ Stomach Ulcers
- ☐ Coronary Artery Disease
- ☐ Pacemaker
- ☐ Heart Murmur
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Irritable Bowel
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Peripheral Vascular Disease
- ☐ Kidney Stones
- ☐ High Cholesterol
- ☐ Osteoporosis
- ☐ Heart Attack
- ☐ **No known Medical Conditions**
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Anxiety
- ☐ Depression
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Mental Illness: _____
- ☐ Benign Prostatic Hypertrophy
- ☐ Rheumatoid Arthritis
- ☐ Cancer: [Type] _____
- ☐ Migraine Headaches
- ☐ Osteopenia
- ☐ Other: _____

Medications: Please list all medications you take on a daily basis, including over the counter medications (including vitamins and herbal supplements) and birth control pills OR: ☐ No Medications Taken

Name of Medication	**Dosage (mg, units, etc)**	**How Often Taken**

REVIEW OF SYSTEMS: Have you had any of the following in the **last 6 months**? Please answer at **each** category.

Constitutional: ☐ none, ☐ weight loss, ☐ weight gain, ☐ fever, ☐ fatigue, ☐ chills

Eyes: ☐ none, ☐ vision change, ☐ blurred vision, ☐ eye pain

Ears/Nose/Throat/Neck: ☐ none, ☐ sore throat, ☐ nose bleeds, ☐ cough, ☐ dizziness, ☐ snoring, ☐ vomiting

Cardiovascular: ☐ none, ☐ chest pain, ☐ palpitations, ☐ exercise intolerance, ☐ light headed when standing

Respiratory: ☐ none, ☐ wheezing, ☐ chest tightness, ☐ coughing up blood

Gastrointestinal: ☐ none, ☐ constipation, ☐ frequent diarrhea, ☐ vomiting, ☐ abdominal pain

Genitourinary: ☐ none, ☐ urinary incontinence, ☐ hematuria (blood in urine) ☐ urinary frequency/urgency

Musculoskeletal: ☐ none, ☐ muscle weakness, ☐ stiffness, ☐ arthralgias (joint pain), ☐ back pain

Dermatologic: ☐ none, ☐ rash, ☐ skin sores, ☐ eczema, ☐ psoriasis, ☐ keloid scars

Neurologic: ☐ none, ☐ tinnitus (ringing in ear), ☐ tremor, ☐ memory loss, ☐ seizures, ☐ spasms ☐ neuropathy

Endocrine: ☐ none, ☐ chills, ☐ flushing, ☐ increased thirst, ☐ hair loss

Hematologic/ Lymphatic: ☐ none, ☐ abnormal bleeding, ☐ easy bruising, ☐ swollen glands

Allergy/Immunology: ☐ none, ☐ runny nose, ☐ sinus pressure, ☐ itching, ☐ hives, ☐ frequent sneezing

How did you hear about us?