

UPPER BUCKS ORTHOPAEDIC ASSOCIATION

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.

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, including deductibles and co-insurance.
- 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.
- X-rays must be performed at your capitated site for all Keystone patients. You can choose to have your X-ray performed in our office for a fee payable at the time of service.

UPPER BUCKS ORTHOPAEDIC ASSOCIATION

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.
- Any refunds to patients who have paid by credit card will be credited back to the card used on that service date.

Release of Information

I authorize Upper Bucks Orthopaedics at Grand View Health and/or their agents:

- To release to my insurance provider, benefit plan, or other third party payer, or their agents, any medical or other information necessary to process related health claims, receive payment or to obtain authorization for services, supplies and equipment in accordance with HIPAA standards.
- To request and to receive directly, on my behalf, claims for benefits and/or appeals of any denied claims or authorization and to take action in my name against my insurance company, benefit plan or other third party payer, to receive any benefits that may be due or payable under the insurance policy or benefit plan.
- To give medical or other information to any healthcare practitioner furnishing health care services to me or receive information from them in accordance with HIPAA standards.

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

Printed Name _____

Date of Birth

Patient name if minor

Signature

Date _____

Relationship to patient: ☐ Self ☐ Parent ☐ Other _____

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.

Name: _____

Date of Birth: _____

Date: _____

GVH GRAND VIEW HEALTH

**UPPER BUCKS ORTHOPAEDICS
AT GRAND VIEW HEALTH**

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

MEDICATION	REACTION
_____	_____
_____	_____
_____	_____

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

<u>Name of Medication</u>	<u>Dosage (mg, units, etc.)</u>	<u>How Often Taken</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History: Please check all that apply: ☐ **No known Medical Conditions**

- | | | |
|--|--|---|
| <input type="checkbox"/> History of MRSA | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression |
| <input type="checkbox"/> DVT (blood clot in leg) | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Leukemia/Lymphoma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Sleep Apnea/CPAP | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Benign Prostatic Hypertrophy |
| <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Cancer: Type _____ |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Reflux | <input type="checkbox"/> Osteopenia |
| | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Other: _____ |

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

- | | | |
|---|--|--|
| <input type="checkbox"/> NO PRIOR SURGERIES | <input type="checkbox"/> Tonsillectomy/adenoidectomy | <input type="checkbox"/> Breast: _____ |
| <input type="checkbox"/> AICD/Pacemaker | <input type="checkbox"/> Other Heart: _____ | <input type="checkbox"/> Appendectomy |
| <input type="checkbox"/> Angioplasty/stent | <input type="checkbox"/> Vascular: _____ | <input type="checkbox"/> C-section |
| <input type="checkbox"/> Hand surgery: _____ | <input type="checkbox"/> Shoulder: _____ | <input type="checkbox"/> Wisdom teeth |
| <input type="checkbox"/> Knee surgery: _____ | <input type="checkbox"/> Spine: _____ | <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> Foot: _____ | <input type="checkbox"/> Eye: _____ | <input type="checkbox"/> Hernia repair |
| <input type="checkbox"/> Ankle: _____ | <input type="checkbox"/> Hip: _____ | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Other Surgeries: _____ | | |



Name: _____

Date of Birth: _____

Date: _____

**UPPER BUCKS ORTHOPAEDICS
AT GRAND VIEW HEALTH**

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

Mother	Father	Brother	Sister	Son	Daughter
<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Bone Cancer <input type="checkbox"/> Lung Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Heart Disease <input type="checkbox"/> Anesthesia Complications	<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Bone Cancer <input type="checkbox"/> Lung Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Heart Disease <input type="checkbox"/> Anesthesia Complications	<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Bone Cancer <input type="checkbox"/> Lung Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Heart Disease <input type="checkbox"/> Anesthesia Complications	<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Bone Cancer <input type="checkbox"/> Lung Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Heart Disease <input type="checkbox"/> Anesthesia Complications	<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Bone Cancer <input type="checkbox"/> Lung Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Heart Disease <input type="checkbox"/> Anesthesia Complications	<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Bone Cancer <input type="checkbox"/> Lung Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Heart Disease <input type="checkbox"/> 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

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

Hip <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Groin <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Pelvis <input type="checkbox"/>
Thigh <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Shin <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Finger: _____
Shoulder <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Clavicle <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Upper Arm <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B
Elbow <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Forearm <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Toe: _____
Hand <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Wrist <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Heel <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B
Knee <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Calf <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Back <input type="checkbox"/> Upper <input type="checkbox"/> Middle <input type="checkbox"/> Lower
Ankle <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Foot <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B	Neck <input type="checkbox"/>

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: _____

Did you have any prior studies related to this visit? ☐ Yes ☐ No If yes, where? _____

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 ☐ chills ☐ snoring
Eyes: ☐ none ☐ vision change ☐ blurred vision ☐ eye pain
Ears/Nose/Throat/Neck: ☐ none ☐ sore throat ☐ nose bleeds ☐ dizziness
Cardiovascular: ☐ none ☐ chest pain ☐ palpitations ☐ shortness of breath ☐ light headed when standing
Respiratory: ☐ none ☐ wheezing ☐ chest congestion ☐ coughing up blood ☐ cough
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
Integumentary: ☐ none ☐ rash ☐ lesions ☐ wounds ☐ skin ulcer
Neurologic: ☐ none ☐ weakness ☐ tremor ☐ memory loss ☐ convulsions ☐ tingling ☐ numbness
Psychological: ☐ none ☐ anxiety ☐ depression ☐ memory loss ☐ confusion
Endocrine: ☐ none ☐ fatigue ☐ flushing ☐ heat intolerance ☐ cold intolerance
Hematologic / Lymphatic: ☐ none ☐ abnormal bleeding ☐ easy bruising ☐ swollen glands





Upper Bucks Orthopaedics at Grand View Health
Board Certified Orthopaedic Surgeons
P 215-257-3700
F 215-257-0360

GVH Outpatient Center
915 Lawn Ave., Main Floor, Sellersville, PA 18960

Harleysville Outpatient Center
270 Main Street, Suite 2, Harleysville, PA 19438

Health Center at Quakertown
99 N. West End Blvd., Suite 108, Quakertown, PA 18951

The Pavilion
419 S. Broad Street, Unit 4, Lansdale, PA 19446

Upper Bucks Orthopaedics at Grand View Health Narcotic Agreement

It is the goal of Upper Bucks Orthopaedics at Grand View Health to provide the best care possible for our patients. In order to reach this goal, it is necessary to provide information to keep our patients informed. Although this letter probably addresses only a few of those who read it, we feel it is important to have this policy available to you.

Our office policy on the use and prescription of narcotics is as follows:

No new narcotic or refill prescriptions will be called in or addressed after 4:00 PM on weekdays or during the weekend – NO EXCEPTIONS. If you feel that you are going to run out of your prescription, please phone us 48 hours prior so your physician may review the request before you run out.

Office Visits:

- NO narcotics will be prescribed for chronic pain. However, narcotics may be prescribed for acute injuries, typically when they are less than one week old.
- If you are under the supervision of a pain management physician, we require you to disclose this information to us on your first visit. Failure to do so would be fraud, and would violate your contract with your pain management physician.

Post-operative and treatment for acute injuries:

- Narcotics will only be prescribed for a period up to **1-3 months** after a surgical procedure (dependent upon the type of procedure performed), and for acute injuries. There are, of course, the occasional exceptions to the rule. We may need to see you to reevaluate your condition prior to renewing your prescription. We may require you are re-evaluated at a minimum of every 3 months prior to any narcotic prescription renewal.
- If you are on chronic narcotics from a pain management physician, you will need to receive your post-operative pain medicine from that physician, unless pre-arranged with us prior to your surgery.
- We will require you to provide a pharmacy on file where all medications will be filled by our office.

As part of keeping our patients informed, we want to make you aware of the reasons why we limit the use of narcotics.

1. Severe postoperative/post injury pain that would require narcotics will usually reduce significantly by 2-3 days after surgery or injury and is typically gone by 10-14 days or 3-4 weeks for more invasive procedures. Postoperative need for narcotics longer than this period may signal complications that need more direct or specific treatment instead of covering up the problem. Typically, however, it is known that a longer need for narcotics more often than not means that you are up doing too much and “chasing” it with narcotics. Although you may desire to be active, it is possible to be “too active.” You need to listen to your body and respond to it. Overall, you will recover more quickly reducing your activities so that your pain is controllable without the need for narcotics. After all, your goal is to make the best recovery from your surgery or injury you can.

2. After 3-7 days, your brain wants to and is supposed to kick in and manage the pain naturally. This is the best way to manage medium and long-term soreness and milder pain. Narcotics are known to block this normal process.
3. Narcotics are proven to be habit forming. Dependency on pain medication can start in as little as 2 weeks after beginning their use. We cannot tolerate allowing this to happen.

In addition, The Drug Enforcement Administration monitors and collects data on narcotics dispensed by a physician. An orthopaedic surgeon is not expected to prescribe narcotics long term. We agree with this policy. Therefore, if you are receiving narcotics from your previous physician or primary care physician, you will need to continue that.

Pennsylvania has instituted the Pennsylvania Prescription Drug Monitoring Program (PA PDMP). This system is a powerful new tool to help combat the opioid epidemic. It is important for you to know that prescribers are required by law to search the PDMP for each patient each time a controlled substance is prescribed, or if there is a reason for concern with your medications. Upper Bucks Orthopaedics will comply with this new rule if a controlled substance is prescribed for you as a patient.

We do not deny that you often have pain; however, it is necessary to be aware of your own ability to tolerate pain and the need to rely on this process in a timely manner. We have created this policy to assist in assuring that our patients receive the best care possible and we appreciate your assistance in enforcing it.

If you have any questions regarding our office policy on the use of narcotics, feel free to contact us so that we can discuss it. In addition, if you feel you need help with long-term (chronic) pain control, we will be happy to guide you to a pain management specialist.

There may become instances when a patient is required to sign a separate narcotic policy if Upper Bucks Orthopaedics is prescribing long term narcotics. Again, our concern is to provide you with the best results possible.

The Physicians and Staff of Upper Bucks Orthopaedics at Grand View Health

Patient Name (Printed)

Date of Birth

Patient Signature

Date

Personal Representative Information (if applicable)

Date

Relationship to Patient



Patient Portal Enrollment Form

Please complete the information below. A Grand View Health representative will set up your portal account and you will receive an email to the email address provided below with instructions to complete your enrollment within the next 2-3 business days.

I understand that patient information within the portal may include information relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, Behavioral Health services/psychiatric care, or treatment for alcohol and/or drug abuse.

Should you like to access patient information for someone other than yourself, please fill out an Authorization for Proxy Access to GVH Patient Portal form.

Patient Name _____

Address _____ City _____ State _____ Zip Code _____

Date of birth (month/day/year) ____/____/____

Phone Number: _____

Medical Record # (if available) _____

Email address _____

Verify Email address _____

Signature _____ Date _____

FOR STAFF USE ONLY

Patient name as shown in EMR: _____

Medical Record # as shown in EMR: _____

DOB as shown in EMR: _____

ID Verified by: _____

Enrollment completed by: _____

(Print Name)

- ☐ Patient Identification
- ☐ Photo ID
- ☐ POA Provided
- ☐ Office
- ☐ Patient Registration
- ☐ Health Information Management

Please present completed Patient Portal Enrollment Form to the Health Information Management Department with photo ID.

