Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address Line 1 _____

Address Line 2 _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address: _____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address Line 1 _____

Address Line 2 _____

City, State _____ ZIP _____

Home Phone _____ Work Phone _____ Ext. _____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM _____/DD _____/YYYY _____

Social Security Number _____-_____-_____ Telephone _____

E -Mail Address _____ Sex ☐ F – Female ☐ M - Male

Address Line 1 _____

Address Line 2 _____

City, State _____ ZIP _____

Employer _____ Employer Phone Number _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ ***Date*** _____

Fairview Specialists- Orthopedics

Patient's Name _____ Today's Date_____ Age _____

Problem(s) you are currently having _____

How long have you been having the problem(s) _____ Is this concerning an accident Yes/No If so, date_____

If an accident, was it related to: Workers Comp _____ Motor Vehicle Accident _____ Other_____

Have you been seen by anyone else for this problem? Yes/No If so, who? _____

Treatment given _____

Did another physician refer you to us? ____ Physician's name _____

Have you had orthopaedic problems in the past? ____ If so, what? _____

Medical History

All current medications

_____

_____

Allergies: _____

Last Flu Vaccination Date: _____ Last Pneumonia Vaccination Date: _____

Last Breast Exam Date: _____ Last Colorectal Screening Date: _____

All past surgeries/Last Hospital Admission

_____

Have you or anyone in your immediate family ever been diagnosed with any of the following conditions?

Please check the box below that applies:

Condition	Self	Family	Condition	Self	Family	Condition	Self	Family
Diabetes			Open Wounds			Depression		
Arthritis			Current Infection			Anxiety		
High Blood Pressure			Presently Pregnant			Substance Abuse		
Heart Disease			Seizures			Previous Surgeries		
Heart Attack			Metal in the Body			Other		
Pacemaker			Cancer/Tumor					
Vascular Disease			CVA/Stroke					
Chronic Headaches			Previous Fractures					
Kidney Problems			Osteoporosis					

Social History

Do you use tobacco? Y___ N___ If so, how much? _____

Do you use alcohol? Y___ N___ If so, how much? _____

Do you use street drugs? Y___ N___ If so, how much? _____

Where do you work? _____ Sitting _____Standing _____

Are you Married? Y___ N___ Do you live alone? Y___ N___

General/Constitutional	**Yes**	**No**
Weakness		
Lack of Appetite		
Fever		

Skin	**Yes**	**No**
Rash		

Cardiovascular	**Yes**	**No**
Chest pain or tightness		
Heart racing		
Swelling of legs		

Respiratory	**Yes**	**No**
Cough		
Shortness of breath		

Gastrointestinal	**Yes**	**No**
Nausea		
Vomiting		
Heartburn		
Abdominal Pain		

Genitourinary	**Yes**	**No**
Urinary Tract Infection		

Musculoskeletal	**Yes**	**No**
Muscle Pain		
Neck Pain		
Shoulder or arm pain		
Back Pain		
Pain down the right leg		
Pain down the left leg		
Painful joints		
Swelling of any joints		
Redness of any joints		
Stiffness of any joints		
Deformity of any joints		
Deformity of any extremities		

OTHER	**Yes**	**No**

It is my responsibility, as the patient, to inform the physician's office of any changes in my medical status.

The above is true and correct.

_____ _____

Signature of Patient of Legal Guardian Date

The information has been verified.

_____ _____

Signature of Physician Date

Fairview Medical Group Orthopaedics

Consent for Treatment and Payment Agreement

I hereby authorize ***Fairview Medical Group Orthopaedics*** to use and/or disclose my health information which specifically identifies me or which can reasonable be used to identify me to carry out my treatment, payment and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to ***Fairview Medical Group Orthopaedics*** of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible for charges not covered. I understand if there is a balance on my account after ninety (90) days, that collection action will be taken. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to *Fairview Medical Group Orthopaedics* all insurance or third party payments that I receive for services rendered to me immediately upon receipt. Patient Initial: _____

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to *Fairview Medical Group Orthopaedics*. Patient Initial: _____

I request this authorization also apply to all other insurance. Patient Initial: _____

I acknowledge that I have been given *Fairview Medical Group Orthopaedics* Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Facility Privacy Official. Patient Initial: _____

RELEASE OF MEDICAL INFORMATION

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below. I understand that I may request individuals to leave the exam room at any time.

Name of Person and phone number who is Authorized to receive information	Release info (please circle)	Allowed in exam room (please circle)
_____(___)_____	Y N	Y N
_____(___)_____	Y N	Y N
_____(___)_____	Y N	Y N

***If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from re-disclosure**

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature_____

Date_____ Patient Date of Birth_____

Fairview Specialists- Orthopedics

PATIENT NAME_____DATE OF BIRTH_____

PATIENT FINANCIAL AGREEMENT

1. **_____(Patient or Guardian Initials)**

Financial Agreement.

- I acknowledge, that as a courtesy, **Fairview Specialists- Orthopedics** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. **_____(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that **Fairview Specialists- Orthopedics** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. **_____(Patient or Guardian Initials)**

Assignment of Benefits. I hereby assign to **Fairview Specialists- Orthopedics** any insurance or other third-party benefits available for health care services provided to me. I understand **Fairview Specialists- Orthopedics** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Fairview Specialists- Orthopedics,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. **_____(Patient or Guardian Initials)**

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **Fairview Specialists- Orthopedics** by the Medicare or Medicaid program.

5. **_____(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for **Fairview Specialists- Orthopedics**, or EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **Fairview Specialists- Orthopedics** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **Fairview Specialists- Orthopedics** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. **_____(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify)_____

FAIRVIEW *Specialists*
ORTHOPEDICS

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**