ORTHOPEDIC ASSOCIATES OF LONG ISLAND

PRECISIONCARE

PATIENT REGISTRATION

Name (Last, First, MI) _____ Sex M F

Date of Birth _____ Age _____ SS#_____ Occupation _____

Street Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Phone _____ Cell _____ E-mail _____ Marital Status _____

Primary Physician Name: _____ Primary Physician Phone: _____

Pharmacy _____ Address _____ Phone _____

Employer _____ Address _____ Phone _____

Spouse/Parent/Guardian Name _____ Phone _____

Parents Employer: Mother _____ Phone _____

Father _____ Phone _____

Race _____ Ethnicity _____ Language _____

Emergency Contact _____ Phone _____

PRIMARY INSURANCE

Insurance Company _____ Phone _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Member ID _____ Group # _____

Person Responsible for Account (Last, First, MI) _____

Relationship to Patient _____ SS# _____ Date of Birth _____

Employer _____ Business Phone _____

Employer Address _____ City _____ State _____ Zip _____

SECONDARY INSURANCE

Insurance Company _____ Phone _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Member ID _____ Group # _____

Person Responsible for Account (Last, First, MI) _____

Relationship to Patient _____ SS# _____ Date of Birth _____

Employer _____ Business Phone _____

Employer Address _____ City _____ State _____ Zip _____

FOR MEDICARE PATIENTS: Is this a Medigap plan? (circle one) Yes No

PATIENT SIGNATURE (if minor, parent or guardian) _____ Date_____

Completed by (sign): _____ Date: _____ Reviewed by: Dr. _____

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INITIAL VISIT HISTORY FORM

Name (Last, First, MI) _____ Sex M F

Date of Birth _____ Age _____ SS#_____ Phone _____

Name of your Primary Care Doctor _____ Phone _____

Referring Physician (if applicable) _____ Phone _____

Reason for today's visit (briefly state history of problem and when symptoms began) _____

_____

Problem due to (check one) _____ car accident _____ work-related injury _____ school injury _____ other

Past Medical History: have you ever been diagnosed with any of the following?

Yes / No	**Yes / No**	**Yes / No**
___ ___ Stroke	___ ___ Cancer	___ ___ Thyroid Disease
___ ___ Ulcers	___ ___ Hepatitis	___ ___ Rheumatoid arthritis
___ ___ Colitis	___ ___Diabetes	___ ___ High blood pressure
___ ___ Asthma	___ ___ Tuberculosis	___ ___ Parkinson's
___ ___ Lyme Disease	___ ___ Heart Disease	___ ___ Bleeding disorder
___ ___ Osteoarthritis	___ ___ Kidney Stones	___ ___ Endocrine problems

Please list any other conditions not listed and specify or explain any conditions above (if appropriate): _____

_____

Medications (please attach additional sheet, if necessary) _____

Past surgical history _____

Allergies _____

Review of Systems: Are you currently having problems with any of the following?

Yes / No	Yes / No	Yes / No
___ ___ Eyes	___ ___ Psychiatric Problems	___ ___ Digestion / Bowels
___ ___ Ears/Nose/Throat	___ ___ Joint Pain	___ ___ Stomach Burning
___ ___ Lungs / Breathing	___ ___ Immune System	___ ___ Cardiovascular Problems
___ ___ Recent Weight Loss	___ ___ Urinary Problems	___ ___ Bruising / Bleeding
___ ___ Weakness / Fatigue	___ ___ Chest Pain	___ ___ Neurologic Problems

Please explain any positive responses from above (and any other medical problems not listed) _____

_____

Family Medical History: List any medical problems of your relatives (ie. Diabetes, cancer…)

Grandparents _____

Mother _____ Father _____

Siblings _____ Children _____

Social History: Occupation _____ Working currently? Yes / No / Retired

Do you smoke? Yes / No / Quit Packs per day? _____ Years smoked? _____

Do you use alcohol? Never / Occasional / Daily / Heavy / History of alcoholism

History of drug use (please list) _____

Circle one: Married / Single / Divorced / Widowed Do you live alone? Yes / No

Are you on a special diet? Why? _____

Do you exercise / play sports (describe briefly)? _____

Completed by (sign): _____ Date: _____ Reviewed by: Dr. _____

ORTHOPEDIC ASSOCIATES OF LONG ISLAND

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name/ D.O.B _____

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the facility and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, sexually transmitted diseases, alcohol and substance abuse treatment information, mental health information, and genetic information.

_____ _____

Signature of Patient or Personal Representative | Print Name of Patient or Personal Representative

_____ _____

Description of personal Representative's Authority | Date

_____ _____

Signature of Facility Representative | Date

EXPRESS AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations. Orthopedic Associates of Long Island may need to disclose my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

If I am unavailable, I expressly permit Orthopedic Associates of Long Island to disclose my protected health information for the purposes of appointment/test/procedure reminders and follow-up to the following individuals:

_____ _____

(Relationship to patient)

_____ _____

(Relationship to patient)

I expressly permit Orthopedic Associates of Long Island to disclose my protected health information for the purposes of appointment / test / procedure reminder and follow-up by leaving such information in the form of a message on the following recorded media:

Home answering machine: _____

Office voicemail: _____

Other (specify): _____

_____ _____

Signature of Patient / Personal Representative / Parent / Guardian | Date

ORTHOPEDIC ASSOCIATES OF LONG ISLAND

PRECISIONCARE

FINANCIAL POLICY

Thank you for choosing Orthopedic Associates of Long Island, a division of PrecisionCare! We are committed the success of your medical treatment and care. For your convenience, we have answered a variety of commonly asked financial policy questions below. If you have any additional questions about any of these policies, please ask to speak with a Billing Specialist.

Which plans do you contract with?
Your physician/surgeon and their assistant(s) may not be an in-network provider with your health care insurance plan. Please check our website, www.oali.com, to check physician insurance participation and hospital affiliation. If you have any questions, you can contact our billing department to obtain details about your surgery or office visit including the estimated amount of money you may be responsible for paying.

When do I pay?
Payment is expected for all copays at the time of the visit. If you do not have insurance or you are covered by an insurance company with which we do not participate, all fees must be paid at the time of visit. We accept payment by cash, Check, VISA, Mastercard, American Express and Discover.

Do I need a referral?
If you have a managed care plan with which we are contracted, you may need a referral from your primary care physician. If we have not received a referral prior to your arrival at the office, there will be a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled or offered an opportunity to assume financial responsibility for the services provided that day.

What if my child needs to see the physician?
A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account. Any issues of payment resulting from separation or divorce documents must be resolved by the parents. We will hold the accompanying adult responsible for all charges unless specific arrangements have been made.

What is my financial responsibility for services?

Office Visits and Office Services

HMO & PPO plans which have a contract
If the services are covered by the plan: All applicable copays are due at the time of the office visit. We ask for immediate payment as soon as any deductible is known. If the services you receive are not covered by the plan: Payment is expected in full at the time of the visit. You will be asked to sign a statement authorizing these services.

HMO with which we are not contracted
Payment in full for office visits, x-rays, injections, and all other charges is expected at the time of the office visit. We will provide the necessary information for you to complete and file your claim directly with the insurance company.

Point of Service Plan or Out of Network PPO
Payment for the copay and non-covered services is expected at the time of visit. We will file an insurance claim on your behalf. Coinsurance and deductibles will be billed after we receive payment from your carrier. All balances due will be payable upon receipt of our statement.

_____

Patient Name and date of birth

ORTHOPEDIC ASSOCIATES OF LONG ISLAND

PRECISIONCARE

Medicare (also Medicare HMO Plans)
We will file the claim on your behalf, as well as any claims to your secondary insurance. Payment for copays or any Services not covered by Medicare must be paid at the time of the visit. If you have regular Medicare as primary and also have secondary insurance, copay will be collected depending on secondary plan. If you have regular Medicare as primary, but no secondary insurance, payment of your 20% coinsurance will be collected at the time of the visit. If Medicare is secondary, you will be billed for any patient responsibility after both insurances have processed.

Worker's Compensation
Prior to your visit, you will need to provide the accident date, claim number, employer information and insurance carrier information. If we have verified the claim with your carrier, no payment is necessary at the time of the visit. Please remember that if the claim is denied, the responsibility for the bill will be yours and payable at our usual and customary fees.

Worker's Compensation (Out of State)
Payment in full is requested at the time of then visit. We will provide you a receipt so you can file the claim with your carrier.

Automobile No-Fault Insurance
Prior to your visit, you will need to provide the accident date, claim number and the insurance carrier information. If the No Fault policy is not in your name, we will need full information on the policyholder. If we have verified the claim with the carrier, no payment is necessary at the time of the visit. Please remember that if the claim is denied, the responsibility for the bill will be yours and is payable at our usual and customary fees. **If a referral is needed from your private carrier, you must obtain one in the event that your no-fault carrier denies your claim.**

Commercial Insurance
Also known as indemnity, "regular" insurance, or has a percentage coverage (eg. "80/20% coverage"). We will file a claim to your insurance company as a courtesy. In the event of a denial of any part of the claim, you will need to pay this bill and deal with your insurance carrier directly.

School Insurance
You must submit the original form from the school's carrier. Please bring a copy of the form with you. If you do not have any other insurance, we will bill the school insurance directly. If you have other insurance, the school insurance is secondary and while we will file the claim with your school carrier, you are responsible for payment.

No Insurance (Self Pay)
Payment in full is due at the time of the visit. We will work with you to settle your account. Please ask to speak with our staff if you need assistance.

SURGERY
If your physician recommends surgery, you will have the opportunity to speak with his executive assistant. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it. If you have a commercial plan or are self-pay, she may request a pre-surgical deposit.

Patient Name Date of Birth _____

Signature _____ Date_____

ORTHOPEDIC ASSOCIATES OF LONG ISLAND
PRECISIONCARE

Patient Authorization, Assignment of Benefits & Financial Agreement

Patient Name_____ Date of Birth_____ Effective Date: 8/1/19

I acknowledge and understand that by signing below, I hereby authorize payment directly to ORTHOPEDIC ASSOCIATES OF LONG ISLAND/PRECISIONCARE, 6 TECHNOLOGY DRIVE, SUITE 100 EAST SETAUKET, NY 11733 www.OALI.com for services rendered to me, as specified more fully below.

1. MEDICARE:

- I authorize my Medicare benefits to be paid to the Practice for services furnished to me by the Practice.
- I authorize the Practice to release to the Centers for Medicare and Medicaid Services ("CMS" or "Medicare") and its agents any information needed to determine my Medicare benefits or the benefits payable for related services.
- I authorize the release of medical information necessary to complete any insurance claim forms and to pay the claim.
- The Practice accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for any deductible and/or coinsurance payment and payment for any non-covered services. Coinsurance and deductibles for covered services will be based upon the charge determination of the Medicare carrier.
- I authorize the release of my information to any MediGap or other health insurance carrier I maintain and authorize payment of these secondary insurance benefits to be made on my behalf to the Practice, if possible.
- My authorization will remain in effect unless I revoke my authorization in writing.

2. OTHER INSURANCE PLAN PARTICIPATION: The Practice maintains a list of its contracts with health care service plans ("Plans"), which identifies the Practice physicians who participate in each Plan. A copy of the current list is available from the Practice at the address, telephone number and/or website listed above.

- I have been informed whether any services rendered to me by the Practice may be provided by a non-participating provider and, if so, (i) that such services by a non-participating provider may result in costs not covered by the Plan and (ii) I am individually obligated to pay the full charges for all such services.
- I understand that the Practice has no contract, expressed or implied, with any Plan that does not appear on the list.
- I have been informed that I am individually obligated to pay the full charges for all services rendered to me by the Practice if my Plan does not appear on the list of Plans maintained by the Practice.

3. **NON-COVERED SERVICES**: I understand that each Plan (*i.e.*, HMOs, PPOs) defines what items and services are covered and what items and services are not covered by the Plan.

- I understand that I will receive an Advanced Beneficiary Notice ("ABN") from the Practice for services that are not or may not be covered by my Plan, and that I will be given the option to accept or decline any non-covered services.
- I accept full financial responsibility for payment for any potentially non-covered services that I have accepted, as reflected on the ABN, if my Plan determines that such service is not covered. Examples of non-covered services include, but are not limited to, services not specified as being covered by a Plan, services not listed in the benefit summary furnished to patients by the Plan, and/or treatment or tests not authorized by the Plan.
- I agree to cooperate with the Practice to obtain all necessary authorizations required by my Plan.

4. **RELEASE OF INFORMATION**:

- I understand that the Practice may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, (1) to any person or corporation that is or may be liable or under contract to the Practice for reimbursement for services rendered, and/or (2) to any health care provider for continued patient care.
- I understand that the Practice may also disclose on an anonymous basis any information concerning my care that is necessary or appropriate for the advancement of medical science, medical education, medical research, and/or for the collection of statistical data or pursuant to State or Federal law.

5. FINANCIAL AGREEMENT:

- In return for the services provided to me by the Practice, I will pay my account at the time service is rendered to me or will make financial arrangements satisfactory to the Practice for payment.
- If my account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action.
- If my account is delinquent, I may be charged interest at the legal rate. I assign to the Practice any benefits of any type under any policy of insurance that insures me or any other party liable to me.
- If my insurance company or Plan designates copayments and/or deductibles, I will pay such copayment and/or deductible amounts to the Practice.
- ***I agree to be primarily responsible for the payment of the Practice's bill.***

_____ _____

Beneficiary Signature or Authorized Party Date