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# PATIENT REGISTRATION FORM

Please PRINT & Complete all information
Mark N/A for Not Applicable & P/D for Patient Declined

Patient Name: _____ Today's Date: _____
Last Name First Name MI

If Minor, Accompanying Parent/Guardian _____ Race: _____

Ethnicity: _____

Date of Birth: _____ Age: _____ Sex: Male Female Languages Spoken: _____

Mailing Address: _____ Birth Order: 1 2 3 4 5 6 7 8 _____

City: _____ State: _____ Zip: _____

Marital Status: Single Married Separated Divorced or Widow (er)

Social Security Number: _____ **Preferred Method of Contact:** Cell Phone / Home Phone

Cell Phone: _____ **Patient/Guarantor's Employer:** _____

Home/Other: _____ Patient Occupation: _____

Email: _____ Work Phone: _____

(Necessary to access e health records)

Primary Care Physician: _____ Does Patient Live in a Nursing Home? YES NO

Referring Physician: _____ Name of Nursing Home: _____

## INSURANCE INFORMATION- REQUIRED COMPLETION

Primary Insurance: _____ Name of Policy Holder: _____

Relationship to Policy Holder: Self/Spouse/Child/Other Policy Holder's Employer: _____

Member ID#: _____ Policy Holder's DOB: _____ Policy's Holder's SSN: _____

Secondary Insurance: _____ Name of Policy Holder: _____

Relationship to Policy Holder: Self/Spouse/Child/Other Policy Holder's Employer: _____

Member ID#: _____ Policy Holder's DOB: _____ Policy's Holder's SSN: _____

## THIRD PARTY LIABILITY INFORMATION – REQUIRED COMPLETION

**Is this visit school, work, or accident related?** YES NO **Type of Accident:** _____

Name of Liability Party: _____ Phone: _____

Third Party Insurance Co: _____ Third Party Policy #: _____

Name of Attorney representing patient related to this service: _____

Attorney Phone: _____ Attorney's Address _____

## EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

### Insurance Assignment and Release

I certify the information above is complete and accurate and I will be responsible for any errors or omissions. I assign directly to Orthopaedic Sports Specialist, d/b/a Ortho LA, all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor/medical group may use my health care information and may disclose my personal information for purposes of coordinating care, obtaining payment for services and determining insurance benefits for related services. This consent will continue until revoked by patient or guardian.

### Medicare/Medigap Authorization

I request payment of authorized Medicare and/or Medigap benefits, be made either to me or on my behalf to Orthopaedic Sports Specialist, d/b/a Ortho LA for services rendered by provider group. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and/or their agents' information needed to determine these benefits or benefits for related services.

_____ _____ _____

Patient/Guardian Printed Name Patient/Guardian Signature Date

*Form Updated 07/27/2017*

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# DISCLOSURE OF FINANCIAL INTERESTS

(Updated July 27, 2017)

Louisiana law and various federal regulations (Stark Law; Patient Protection, and Affordable Care Act) require physicians and other health care providers to make certain disclosures to a patient when they refer a patient to those entities for certain designated health care services. (R.S. 37;1744 and LAC 46; XLV, 4211-4215).

Please be advised that Orthopaedic Sports Specialists of Louisiana d/b/a Ortho LA and/or one or more of its staff physicians (David W. Elias, M.D., Patrick R. Ellender, M.D., Jason A. Higgins, M.D., John C. Hildenbrand, M.D.; and/or Richard A. Morvant, Jr., M.D.) may have an economic interest in one or more of the following entities:

- Bayou Regions Surgical Center
- Cypress Clinical Labs of Louisiana, L.L.C
- Health Scripts of America Central Louisiana LLC
- Thibodaux Physician Investors, L.L.C.
- Thibodaux Surgery Center, L.L.C.
- Venture Medical L.L.C.

## PATIENT ACKNOWLEDGEMENT

Subject to insurance limitations and coverages, patients have the right to choose their health care providers. By signing below, you or your legal representative, acknowledge that you have received, read, and understand this disclosure of financial interests in advance of referral to any of the entities listed above.

Patient Name: _____ Date of Birth: _____
(Please Print)

_____ _____
Signature of Patient or Patient Representative Date

Copy of this signed document shall be scanned to the patient medical record under the patient demographics tab.

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# NOTICE OF PATIENT FINANCIAL RESPONSIBILITY

Updated and Effective October 9, 2017

Our office provides services in good faith that it will be appropriately compensated, at time of service. It is your responsibility to understand your individual health policy. Ortho LA will file with your primary and secondary health insurance; but requires timely payment from both insurance and the patient.

Patients are responsible for letting us know of any changes in insurance coverage or other pertinent demographic information prior to services being rendered. You must provide our office with your current insurance card(s) as well as a current state issued photo ID or driver's license with each and every visit. Non U.S. Citizens must provide copy of their passport. If you do not provide us with the correct insurance information and benefits are reduced or denied as a result, you will be responsible for charges incurred.

Deductible, copayments & coinsurance are due at time of service. As part of our insurance contracts and government regulation, we are not allowed to write off patient coinsurance and deductibles.

Outstanding patient balances must be paid prior to new appointments being made. We reserve the right to charge an Administrative Fee of $25.00 for regenerating patient statements on non-payment and/ or partial payments of accounts. Late/ partial payment fees are not covered by insurance and are the responsibility of the patient/ guarantor. Subject to CMS rules & restrictions for Medicare patients.

All outstanding patient balances, deductibles, coinsurance & estimated deposits must be paid in full at least 3 business days prior to an elective surgery.

We will coordinate with your employer for work related injuries. It is the patient's responsibility to let us know if a visit is work related and to provide all necessary details prior to services being rendered so we may follow appropriate regulations.

We do not coordinate with third party liability (example: MVA). If we are contracted with your health insurance company, we will submit a claim to your health insurance. You will still be responsible for deductible, copayments, and coinsurance at time of service. If you do not have health insurance or your health insurance denies coverage due to a third party liability, then you will be held responsible for all non-covered charges. We will not suspend patient collections based on the outcome of a third party liability claim. You are obligated to provide us with accident detail information and contact information on legal representation. Unpaid claims will be forwarded to our attorney for lien placement and collections.

Interest, penalty, & collection costs including but not limited to attorney's fees incurred in order to obtain patient payment are the responsibility of the patient/ guarantor.

Patients are expected to honor their scheduled appointment times. Missed appointments are subject to a fee.

I have received, read, and understand Orthopaedic Sports Specialists of Louisiana, d/ b/ a Ortho LA Notice of Patient Financial Responsibility Policy. I understand my right and responsibilities and also agree to abide by this policy.

Patient/ Legal Guardian Signature _____ Date _____

Patient Name _____ Patients Date of Birth _____
(Please Print)