Performance Orthopaedics and Sports Medicine
Office: (404) 973-2444 – Fax: (404) 935-9832
www.performanceATL.com

PATIENT REGISTRATION INFORMATION

PATIENT NAME: ______________________ DOB: ______________ AGE: __________

PATIENT ADDRESS: ____
ADDRESS CITY STATE ZIP

MAIN PH: ______________ SECONDARY PH: ____________________ MAIL: ________________

REFERRED BY: ________________________ PRIMARY PHYSICIAN: ____________________

MOTHER: ____________________________ FATHER: ____________________________

ADDRESS (if different): ______________ ADDRESS (if different): ______________

CITY, STATE, ZIP: ___________________ CITY, STATE, ZIP: ___________________

HOME PHONE: _______________________ HOME PHONE: _______________________

WORK PHONE: _______________________ WORK PHONE: _______________________

MOBILE PHONE: _____________________ MOBILE PHONE: _____________________

EMAIL: ____________________________ EMAIL: ____________________________

EMERGENCY CONTACT

NAME: __________________________________ RELATIONSHIP: ____________________

PHONE HOME: ______________ MOBILE: ________________ WORK: ________________

RESPONSIBLE PARTY

LEGAL NAME: ____________________________ RELATIONSHIP TO PATIENT: ____________

DOB: ____________ SS#: ________________ EMAIL: ____________________________

ADDRESS: ____
ADDRESS CITY STATE ZIP

PHONE HOME: ______________ MOBILE: ________________ WORK: ________________

EMPLOYER: ____

INSURANCE INFORMATION

PRIMARY INSURANCE CO: ___________________________ PHONE: ____________________

POLICY #: ________________ MEMBER ID: ________________ GROUP #: ________________

SECONDARY INSURANCE CO: _________________________ PHONE: ____________________

POLICY #: ________________ MEMBER ID: ________________ GROUP #: ________________

PLEASE READ: Your signature gives us permission to bill your insurance and discuss your office visits with all appropriate parties and to process and receive payment from your insurance provider. We will file your insurance for you as a courtesy, but this does not mean services will be covered and all charges are the responsibility of the patient and responsible party. If claims are paid in a timely manner, you will be billed for charges in full. All insurance updates to our office are the responsibility of the patient and responsible party. I hereby assign to and authorize payment directly to Performance Orthopaedics and Sports Medicine and all benefits payable under the terms of any insurance policy provided to us if it is filed by our office. Should collection proceedings become necessary, you agree to pay all costs of collection including reasonable attorney's fees. I authorize the release of any medical information necessary to process my insurance claims or continue my medical care. I acknowledge that I have been provided access to notice of privacy practices of Performance Orthopaedics and Sports Medicine.

____ ____________________

SIGNATURE OF PATIENT OR GUARANTOR DATE

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Orthopaedics & Sports Medicine

Durable Medical Equipment (DME) List/Cash Items

****Please read our office policies below and sign at the designated line****

This document is intended to clarify what is deemed DME according to most insurance carriers. Georgia state law states that DME**: 1) Must be appropriate for home use (902.1), 2) Must be able to with stand repeated use (902.2), 3) Must be medically necessary (902.3), 4) Must have a warranty (902.4).** Most DME will be filed to insurance however, if the patient has a deductible or co-insurance the allowable amount will be collected at the time of service.

DME: The following list of supplies will **NOT** be covered by your insurance carrier and will be collected in full at the time of service. This is for ALL insurance plans.

CODE	SUPPLY	CHARGE
A6449	Ace Wrap 2"/3"/4"	$6/$8/$10
L3170	Heel Cups	$65
A4565	Arm Sling	$30
L3260	Cast Shoe	$20
L1825	Neoband Knee	$60
L1902	Crutches	$70
A4570	Finger Splint	$25

Gortex/Fiberglass: These items are materials we use to cast our patients. They are not covered by insurance carriers and are considered out of pocket expenses to patients. Payment for these items are due at time of service.

CODE	SUPPLY	CHARGE
Q4050	Gortex 2"/3"	$44/$56
A4590	Fiberglass 2"/3"/4"	$15/$20/$25

Casting: Please be advised that additional cast applications/repairs required prior to designated follow up date, due to excessive wear and tear, water damage, foreign object insertion, color, or not wearing proper equipment given, will result in an additional cost. You will be charged $50.00 for any cast repair or replacement and materials at time of check in.

Patient Name (print) ____

Patient/Parent Signature ____

Date ____

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Financial Policy

In order to reduce confusion and misunderstanding between our patients and the office, we have adopted the following financial policy. If you have any questions, please discuss them with one of our patient collection specialists. We are dedicated to providing the best possible care to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- **Fees** - Your insurance is an agreement between you and your insurance company. As a courtesy to you, we will file your insurance claims for you if you assign benefits to the physician. A prepayment of your deductible and coinsurance will be required for your portion of our fees, based on our contract allowable rate. Any balance remaining after your health plan pays its portion is your responsibility and payment for this balance is due upon receipt of a statement from our office. For your convenience, we accept cash, check, Care Credit and all major credit cards.
- **Coverage** - All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. We highly recommend that you READ YOUR INSURANCE BOOKLET or a copy of the contract your policy falls under to determine your benefits.
- **Insurance Terms** - You will be responsible for promptly responding to your insurance company to provide any additional information they may request regarding your treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in your account becoming due and payable, in full, immediately.
- **Be prepared -** to present your insurance card and proof of identity (e.g. driver's license) at each visit. You will be responsible for providing a change of address, telephone number and/or insurance information any time a change occurs.
- **No Show Fee** – If you do not cancel or reschedule your appointment 24 hours in advance of your appointment time a $50 No Show Fee will be added to your account and must be paid before making any future appointments. This fee will not be waived!
- **Please be aware of the following medical records related fees**: Medical Records copies-$25; CD of Images-$10; FMLA $35 and Disability Forms $45.
- ****Surgery Cancellations**:** Patients are expected to give a minimum 7 day cancellation notice when unable to keep a surgery or procedure appointment. If you do not contact our office with the appropriate notice you will be charged a $250.00 service fee. This notice allows our office to schedule other patients for procedures in order to best utilize the time available to care for our patients.
- **Please note there are no refunds or returns on all braces/soft good, once they are used!**

We will look to the adult accompanying a minor for payment of all services rendered to minor patients.

When you are charged a "global" fee for surgery or office care of a fracture etc., that fee not only includes the service on the day it is performed, but includes <u>routine follow-up care as well</u>. The global period ranges from 10-90 days depending on the procedure and your health plan. Injections, X-rays, and supplies (such as casting or dressing materials, splints, *braces, etc.) are <u>not</u> included in the "global" fee and a charge will be made for these items. Services related to <u>complications</u> are <u>not</u> included in the global fee.

I have read and understand the financial policy outlined above, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by Performance Orthopaedics & Sports Medicine.

____ ________________

Signature **Date**

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FRACTURE CARE

If Applicable

Dear Parent or Guardian:

Our Office makes every effort to follow the current coding practices for reporting medical services as dictated by the Federal government (CMS) and the American Medical Association (the AMA). These regulations can be quite complicated and generate many questions. The purpose of this handout is to clear up any confusion caused by these complicated rules regarding the billing of fracture care services.

A fracture or "broken bone" is most often diagnosed by x-ray and can vary greatly in severity and treatment options. However for billing and insurance coding purposes, fracture care is listed in the surgery section of the AMA's (American Medical Association) coding book and is subject to Global or Surgical rules regardless of whether these services were provided at the hospital or in the office.

An insurance claim for fracture care will typically appear as follows:

1) An **Exam** (99200 code series) for diagnosis and decisions about the best treatment options.

2) An **X-ray** (70000 codes) is used to diagnose the fracture. Even if you bring xrays with you, additional views may be required. A post fracture treatment xray may be taken to ensure proper alignment of the fracture has been maintained.

3) A **Fracture Code** (20000 codes) will be assigned based on the site, type of fracture and whether the treatment is closed or open. Open treatments, and closed treatment requiring manipulation of the fracture, are performed in an Operating Room at the hospital or out-patient surgery facility. Closed treatment that does not require manipulation may be done in the office. However, **all fracture treatment is considered "major surgery" by the Federal (CMS) and AMA coding systems and will oftentimes be reported as surgery on your insurance company's "Explanation of Benefits." This includes clavicles (collar bones), hands and feet.**

4) The **Initial Cast Application** (29000 codes) is included in the above Fracture Code at no charge. Subsequent applications are separately reportable and billable.

5) **Casting Supplies** are reported and billed separately.

6) **Subsequent Fracture care**: Most "routine" fractures will require several post operative visits which are included at no charge in the original fracture/surgical fee **if related to the same diagnosis**. The post operative/global days are standardized by diagnosis code. **Subsequent x-rays** (70000 codes), **cast applications** (29000 codes) **and supplies are not covered under the global period and are billable.**

Some of the more serious type of fractures may need additional surgery or procedures. There are special rules and modifiers our office is required to use to report those services.

This office is required by the Federal Compliance laws to report the services provided based on the documentation in the medical records. We cannot improperly alter a claim for the purpose of obtaining payment, nor can we discount patient copays and deductibles. If you discover a bona fide billing error, duplicate charge or other posting error, we would greatly appreciate bringing the matter to the attention of our Office staff or administrator for further investigation and proper corrective action if appropriate.

As you know, coverage and payment amounts vary greatly by payer. If you have any questions about your particular coverage, it is best to check with your company's representative or insurance carrier. Our business Office staff will be happy to assist you in the claims filing process for prompt adjudication and payment of your insurance claim. Remember that insurance is a contract between you and your insurance carrier. Final responsibility for payment of your account rests with you.

I have read and understand the above information.

Child's Name: _________________________________ DOB: _______________________

Legal Guardian:_________________________________ Date: _______________________

PLEASE ASK FOR A COPY OF THIS SHEET FOR YOUR FILES

Patient Health Information Release Authorization Form

Your health and medical information are considered sensitive and private and is afforded protection under the law. However, there are circumstances in which you may want our office to release this information to someone other than yourself. Please list those individuals below that may have access to your health and medical information. These individuals will be able to call our office and receive information over the phone, schedule or change appointments, pick up health records or accompany a minor patient to visits.

Please list the names and relation of the person(s), you would like to give authorization for Performance Orthopaedics and Sports Medicine, to release personal health information to below:

1. ____ Relation: ___________________________________

2. ____ Relation: ___________________________________

3. ____ Relation: ___________________________________

Check to Decline this Release Authorization

______ I decline to have anyone pick up or call for patient information on my behalf.

____ _________________________

Signature of Patient or Legal Representative Date

____

Relationship to Patient

____ _________________________

POSM Representative/Witness Date

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I hereby acknowledge having reviewed and/or received the following information and policies from **Performance Orthopaedics and Sports Medicine** (POSM): HIPAA use and disclosure policy (privacy policy), financial policy, office policies and procedures.

____________________________________ __________________
Patient Name (please print) Date

____________________________________ __________________
Patient/Responsible Parties Signature Date

____________________________________ __________________
Signature and Title of Staff / Witness Date

For Clients Unable to Acknowledge Receipt

I hereby certify that the client was unable to acknowledge receipt of the POSM's policies because:

____

____

____________________________________ __________________
Signature of POSM Staff Date

____________________________________ __________________
Provider Date form completed