



## **ORTHOPAEDIC ASSOCIATES OF READING, LTD.**

### **Financial Policy**

#### **GENERAL POLICY**

Orthopaedic Associates of Reading participates with many insurance plans. As a participating provider we will accept the carrier's allowable amount. Patients are responsible for **co-payments, co-insurance amounts and/or deductibles** and payment for services not normally covered by the carrier. Copays will be collected at each visit. If copays and past due balances are not paid, your appointment may be rescheduled and payment must be made prior to the next scheduled visit. **If you are insured under a plan that we do not participate with and you choose to receive your care with us, we can make arrangements to courtesy bill the carrier, however, the patient is responsible for the bill in it's entirety.**

Please remember that your insurance plan is a contract between you and your insurance carrier. This contract usually requires a shared responsibility between the insurer and the patient in payment for our services. While we will act on your behalf to obtain payment for our services, once we have exhausted all efforts, the patient is responsible for the balance due. The Billing Department at Orthopaedic Associates of Reading can develop a payment plan to suit your needs to ensure that your account remains in good standing, should this become necessary. Our office also accepts Visa, Mastercard and Discover in addition to cash and personal checks as methods of payment.

#### **REFERRALS**

If your insurance requires a referral form from your PCP for your visit with our practice, the referral must be obtained by the patient and presented to us at the time of the visit. If a referral from your PCP is not present at the time of the visit, the visit will be rescheduled to allow time to contact your PCP and arrange for a referral.

#### **SECONDARY INSURANCES**

We strive to provide complete billing service to our patients. We will submit your secondary insurance claim a maximum of two times. After two submissions without a response, the balance will be billed to the patient. **Our office will not file to tertiary insurances, but will provide you the necessary documents to do so upon request.**

#### **SELF-PAY POLICY**

Patients without insurance coverage who wish to receive care with us must establish a payment plan with our billing department prior to receiving services or immediately after receiving emergency services.

#### **COLLECTION ACCOUNTS**

Our office will make every effort to communicate with you about your account and will present reasonable options for payment. In the event that we involve a third party for collection of an account, we will add an additional fee of \$25 to your account for administrative costs involved. You will not be permitted to return for a new episode of care until you have satisfied the old debt.

#### **CHECKS RETURNED FOR INSUFFICIENT FUNDS**

If we receive a returned check for insufficient funds, we will immediately reverse the payment on your account, thereby adding the amount back onto your account and we will also charge a **\$20 fee** to your account.

#### **DISABILITY INSURANCE FORM COMPLETION**

Our office will complete your disability insurance claim forms. The fee for each form is \$10 and must be paid in advance of or at the time you receive your completed form. If you have asked us to mail your form directly to your insurance company, you will be required to pay the \$10 fee when you drop the form off at our offices.

#### **COLLECTION OF DEDUCTIBLES FOR ELECTIVE SURGERIES**

When you choose to schedule a surgery with one of our physicians, we will check with your insurance carrier for any outstanding deductible amounts. If there is a deductible amount not yet satisfied for the benefit period, you will be asked to pay a portion of that deductible at the time you schedule your surgical procedure.

I have read the Financial Policy as outlined above.

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Patient/Guardian Signature

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Date

Rev.  
2/09

# Orthopaedic Associates of Reading, LTD.

## **PATIENT INFORMATION:**

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Patient's Height: \_\_\_\_\_ Patient's Weight: \_\_\_\_\_

## **MEDICATIONS/ALLERGIES:**

List your current Medications & doses: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List Allergies to medications or substances: \_\_\_\_\_

\_\_\_\_\_

## **MEDICAL HISTORY:**

Check (✓) you have or have had in the past.

- |   |  |   |   |  |
|---|--|---|---|--|
| <input type="checkbox"/> AIDS               | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Pacemaker        | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> HIV Positive       | <input type="checkbox"/> Pneumonia        | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Polio            | <input type="checkbox"/> Ulcers          |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Other           |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gout                | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Rheumatic Fever  | _____                                    |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Multiple Sclerosis |   | _____                                    |
| Type: _____                                 |  | <input type="checkbox"/> DVT                |   |  |

## **REVIEW OF SYSTEMS**

Check (✓) you have or have had in the past.

- |   |  |  |   |
|---|--|--|---|
| <b>GENERAL</b>  | <b>GASTROINTESTINAL</b>                            | <b>EYE,EAR,NOSE,THROAT</b>                       |   |
| <input type="checkbox"/> Chills                                   | <input type="checkbox"/> Poor Appetite             | <input type="checkbox"/> Bleeding Gums           | <input type="checkbox"/> Hay Fever        |
| <input type="checkbox"/> Depression/Nervousness                   | <input type="checkbox"/> Bloating                  | <input type="checkbox"/> Blurred Vision          | <input type="checkbox"/> Nosebleeds       |
| <input type="checkbox"/> Dizziness/Fainting                       | <input type="checkbox"/> Bowel Changes             | <input type="checkbox"/> Double Vision           | <input type="checkbox"/> Sinus problems   |
| <input type="checkbox"/> Fever                                    | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Difficulty Swallowing   | <input type="checkbox"/> Ringing in ears  |
| <input type="checkbox"/> Headache                                 | <input type="checkbox"/> Rectal Bleeding           | <input type="checkbox"/> Earache/Ear discharge   | <input type="checkbox"/> Persistent Cough |
| <input type="checkbox"/> Loss of Sleep                            | <input type="checkbox"/> Vomiting Blood            | <input type="checkbox"/> Vision:Halos/Flashes    | <input type="checkbox"/> Hearing Loss     |
| <input type="checkbox"/> Loss of Weight                           | <b>GENITO-URINARY</b>                              | <input type="checkbox"/> Cataracts               | <input type="checkbox"/> Glaucoma         |
| <input type="checkbox"/> Numbness                                 | <input type="checkbox"/> Blood in Urine            | <b>SKIN</b>                                      | <b>WOMEN ONLY</b>                         |
| <input type="checkbox"/> Sweats                                   | <input type="checkbox"/> Freq./Painful Urination   | <input type="checkbox"/> Bruise easily           | Date of last: _____                       |
| <b>MUSCLE/BONE/JOINT</b>  | <b>CARDIOVASCULAR</b>                              | <input type="checkbox"/> Hives                   | Menstrual period _____                    |
| Pain, weakness, numbness in:                                      | <input type="checkbox"/> Chest Pain                | <input type="checkbox"/> Itching/Rash            | Mammogram _____                           |
| <input type="checkbox"/> Arms <input type="checkbox"/> Hips       | <input type="checkbox"/> High/Low Blood Pressure   | <input type="checkbox"/> Scars                   | Pap smear _____                           |
| <input type="checkbox"/> Back <input type="checkbox"/> Legs       | <input type="checkbox"/> Irregular/Rapid Heartbeat | <input type="checkbox"/> Changes in moles        |   |
| <input type="checkbox"/> Feet <input type="checkbox"/> Neck       | <input type="checkbox"/> Poor Circulation          | <input type="checkbox"/> Sore that won't heal    |   |
| <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders |  | <input type="checkbox"/> Lump in testicle/breast |   |

*Please turn the page over and complete the back side of the form*

## **HOSPITALIZATION/SURGERY:**

Year	Hospital	Reason for Hospitalization/Type of Surgery

Have you ever had a blood transfusion?  No  Yes  
 If yes, please give dates: \_\_\_\_\_

Have you ever had any complications from anesthesia?  No  Yes

**FAMILY HISTORY:** Any blood relatives with the following:

(✓)	Disease	Relationship to you
	Arthritis	
	Asthma	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Gout	
	Hay Fever	
	Heart Disease	
	High Blood Pressure	
	Kidney Disease	
	Strokes	
	Tuberculosis	
	Other	

**HEALTH HABITS:**

Check (✓) substances you use and amount.

- Caffeine \_\_\_\_\_
- Tobacco \_\_\_\_\_
- Drugs \_\_\_\_\_
- Other \_\_\_\_\_

Living Arrangements:

- Live alone
- Live with someone
- Live in single level home
- Live in multi level home

**DEMOGRAPHIC INFORMATION:**

Home Address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 \_\_\_\_\_ Email Address: (optional) \_\_\_\_\_  
 Telephone Number: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT:**

Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any of his/her staff responsible for any errors or omissions that I may have made in completion of this form

Signature \_\_\_\_\_ Date \_\_\_\_\_

Orthopaedic Associates of Reading  
PATIENT INSURANCE INFORMATION FORM

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Signature on File**

- ✓ I authorize use of this information on all my insurance submissions.
- ✓ I authorize release of information to all my Insurance Companies.
- ✓ I authorize my Medigap insurer (if applicable) to pay claims directly to my provider
- ✓ I understand that I am responsible for my bill.
- ✓ I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies
- ✓ I authorize payment directly to my doctor.
- ✓ I permit a copy of this authorization to be used in place of the original.
- ✓ I have received a copy of The Notice of Protected Health Information Practices.

**Check One Insurance Type**

**Medical Insurance** \_\_\_\_\_

- Name of Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Worker's Comp**

- Employer Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_
- Insurance Carrier Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_
- Date of Accident \_\_\_\_\_
- Claim Number \_\_\_\_\_
- Contact Name \_\_\_\_\_

**Auto**

- Auto Insurance Name \_\_\_\_\_
- Address \_\_\_\_\_
- Telephone Number \_\_\_\_\_
- Claim Number \_\_\_\_\_
- Contact Name \_\_\_\_\_
- Date of Accident \_\_\_\_\_
- State where accident occurred \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_