Payment Policy

Thank you for choosing us as your Orthopedic Specialist. We are committed to providing you quality and affordable healthcare. Please understand that payment of your bill is part of this treatment and care. This policy was drafted in an effort to clarify any questions you may have regarding payment of your medical care. Please read and sign this document. A copy of it will be provided to you upon request. Please ask to speak with a Billing Specialist if you have any questions or concerns.

1. **Payment Methods** – We accept cash and personal check, as well as, VISA, MasterCard, and Discover credit/debit cards. Postdated personal checks are *not* accepted. You are expected to plan to bring with you an acceptable method of payment when you schedule your appointment.
2. **Copayments, Deductibles, and Coinsurances** - Our contract with your insurance carrier requires that we collect from you any amounts they have deemed patient responsibility according to the Explanation of Benefits they provide us. *There are no exceptions to this rule.* Payment for patient cost shares will be handled as follow, except in the case of surgery and the purchase of durable medical equipment or orthotics.
    a. *Copayments* – Copayments are due on the date of service, prior to receiving any services. If you are in a 90 day global period for any major surgical/fracture procedure there is no copay for the visit with the physician to verify the healing of the affected body part. However, any additional services during the 90 day global period are billed to your insurance and may incur a copay as determined by your insurance carrier. Copays on additional services will be billed to you once your insurance has processed the claim.
    b. *Deductibles* – If your insurance policy carries a deductible and your visit occurs prior to satisfaction of that deductible you will be expected to pay a $60.00 deposit for services prior to receiving services. This is only a deposit towards your expected patient responsibility. Your actual responsibility will be determined once your insurance has completed processing of the claim. Any balance above the $60.00 deposit will be billed to you.
    c. *Coinsurance* – Coinsurances vary greatly as do insurance allowances for services. As such, you will not be required to pay coinsurances on the date of service and instead will be billed these amounts after your insurance processes the claim.
3. **Surgery Cost Shares** – Once it is determined that you require surgery, our staff will contact your insurance carrier for a quote of benefits. *Please understand that a quote of benefits is not a guarantee of payment by your carrier.* Our staff will generate an estimate of patient responsibility based on the quote provided by your carrier. You will be expected to pay a deposit towards your cost share a minimum of 10 days prior to the surgery date, unless the physician deems the surgery is urgent, in which case you will be expected to pay a deposit towards your cost share at the time of scheduling the surgery. Your deposit will be 80% of your expected cost share. The remaining amount of your cost share will be billed to you after the insurance has processed the claim.
4. **Durable Medical Equipment (DME) and Orthotic Cost Shares** – Once it has been determined that a DME or an orthotic is required for proper healing of your condition, our staff will contact your insurance for a benefit quote, while you wait in our office. Again, *a quote of benefits is not a guarantee of payment by your insurance company.* Based on the benefit quote, we will determine the estimated patient responsibility for the item which you will purchase. 100% of the estimated patient responsibly is due prior to leaving the office with the DME or orthotic. If once the insurance company processes the claim they determine a higher cost share that what we had estimated, you will be billed the balance on the DME/orthotic item.

Patient Information

Which Doctor are you seeing today?________________________________

Referred By:__________________ Private Physician: __________________

Patient's Name:__________________ D.O.B.:__________ Age:________

Sex:_____ Height:_____ Weight:_____ SSN: ______________ Marital Status:________

Address: ____________________ City:____________ State:_____ Zip:______

Primary Phone: __________ Secondary Phone: __________ Email Address: ____________

Patient's Employer: ________________________________

Employer's Address: ________________________________

Occupation: ________________ Length of Employment:________ Phone: ____________

Spouse/Parent Name:__________________ D.O.B.: __________SSN: ______________

Spouse/Parent's Employer: ________________________________

Occupation: ________________ Length of Employment:________ Phone: ____________

Emergency Contact: ________________ Relationship:________ Phone: ____________

Primary Health Ins.:________________ ID#:________________ Group#:________

Policyholder's Name: __________________ D.O.B.: __________SSN: ______________

Employer: ________________________________

Secondary Health Ins.:________________ID#:________________ Group#:________

Policyholder's Name: __________________ D.O.B.: __________SSN: ______________

Employer: ________________________________

Is another Ins. Primary to Medicare? _____ If yes, what? __________________

Is another Ins. Primary to Medicaid? _____ If yes, what? __________________

Were you injured on the job? _____Injury Date: ______ WCB#:________ Carrier Case #:________

Insurance Carrier for Employer:________________________________

Address:________________________________

Work Status: ________________________________

Were you injured in an accident? ______ Auto? ______ Liability? ______ Date: ________

Work Status: ________________________________

Name of Insurance Company:________________________________

Address of Insurance Company:________________________________

Claim or Policy #:__________________________

I hereby give my consent to Buffalo Orthopaedic to use and disclose protected health information about me to carry out treatment, payment, and health care operations; and I authorize payment of medical benefits to the named physician/practice for services rendered. If professional collections are necessary, I understand I will incur additional fees as the patient or guardian.

Signature of Patient or Guardian:__________________ Date: ________

Printed Name of Patient or Guardian:__________________

Medical History

Patient's Name:______________________ Date:__________

Reason for Visit:______________________ Duration:______________________

If Injury or Accident, give History:______________________ Date of Injury: __________

Allergies: List all allergies to medications or other items. And the nature of the reactions:

1. ______________________ ______________________
2. ______________________ ______________________
3. ______________________ ______________________

Medications: List all medications currently taking

	Drug	Strength	Dose (How often)
1.			
2.			
3.			

Surgery: List all operations, in-patient or ambulatory. Any Anesthesia Complications.

	Operation	Year		Operation	Year
1.			2.		
3.			4.		

Using any devices like a cane or walker, etc.? ______________________

Conditions you have or had in the past: (If not listed, please describe:______________________)

AIDS _____	Cancer _____	Hepatitis _____	Mononucleosis _____	Suicide Attempt _____
Alcoholism _____	Chemical Depend. _____	Hernia _____	Mumps _____	Hypertension. _____
Anemia _____	Chicken Pox _____	Herpes _____	Pacemaker _____	Hyperthyroidism _____
Anorexia _____	Diabetes _____	High Cholesterol _____	Pneumonia _____	Tonsillitis _____
Appendicitis _____	Emphysema _____	HIV Positive _____	Polio _____	Tuberculosis _____
Arthritis _____	Epilepsy _____	Kidney Disease _____	Prostate Prob. _____	Typhoid Fever _____
Asthma _____	Glaucoma _____	Liver Disease _____	Psychiatric Prob. _____	Ulcers _____
Bleeding Disorder _____	Goiter _____	Measles _____	Rheumatic Fever _____	Vaginal Inf. _____
Breast Lump _____	Gonorrhea _____	Migraine Headache _____	Scarlett Fever _____	Venereal Dis. _____
Bronchitis _____	Gout _____	Miscarriage _____	Sleep Apnea _____	GERD. _____
Bulimia _____	Heart Disease _____	Multiple Sclerosis _____	Stroke _____	

Symptoms you have or had in the past year: (If not listed, please describe:______________________)

General
- Chills _____
- Depression _____
- Dizziness _____
- Fainting _____
- Fever _____
- Forgetfulness _____
- Headache _____
- Loss of sleep _____
- Loss of weight _____
- Nervousness _____

Muscle/Joint/Bone

Pain, weakness, numbness in:
- Arms _____
- Hips _____
- Back _____
- Legs _____
- Feet _____
- Neck _____
- Hands _____
- Shoulders _____

Skin
- Bruise easily _____
- Scarring _____
- Rash _____

Genitourinary
- Blood in urine _____
- Lack of control _____

Gastrointestinal
- Poor appetite _____
- Bloating _____
- Bowel changes _____
- Constipation _____
- Diarrhea _____
- Excessive hunger_____
- Excessive thirst _____
- Gas _____
- Hemorrhoids _____
- Indigestion _____
- Nausea _____
- Rectal bleeding _____
- Stomach pain _____
- Vomiting _____

Cardiovascular
- Chest pain _____
- High Bld. Pres. _____
- Low Bld. Pres. _____
- Irregular heartbeat _____
- Poor circulation _____
- Varicose veins _____

Eye, Ear, Nose, and Throat
- Bleeding gums _____
- Vision problems _____
- Hoarseness _____
- Earache _____

Sweats ______ Frequent urination _____ Painful urination ____ Loss of hearing _____ Nosebleeds _____

Flu Symptoms _______

Medical History Continued

Family History: List any medical illnesses in each member

Father: ______________________________

Mother: ______________________________

Brothers: ______________________________

Sister: ______________________________

Grandparents: ______________________________

Children: ______________________________

List any other disease which occurs in your family and the relationship to you: ______________________________

____

Personal Habits

Do you currently use tobacco? ______ In the past? _______ Never _______ Type and amount: __________________

Do you currently use alcohol? ______ Type: __________________ Never _______ Weekly amount: __________________

Do you use drugs? _________________

Diet History: Describe any special diet habits you follow.

____

Exercise History: Describe what type of exercise you perform and how often.

____

Educational History: List highest grade completed or degree received.

____

Occupational History: Describe the current work you perform or may have in the past.

____

Are you currently working? ______________________________

Please include any questions or comments not already on this form.

____

____

____

Signature of Patient or Guardian:______________________________ Date: _____________

Reviewed by (Physician): ______________________________ Date: _________________

______________________________ Date: _________________

______________________________ Date: _________________

______________________________ Date: _________________