The Westfield Orthopedic Group, Chartered

PATIENT AGREEMENT

In order to accommodate the needs and requests of our patients, we participate in numerous managed care insurance programs. While we are pleased to be able to provide this medical service to you, the **Westfield Orthopedic Group cannot be aware of all the individual requirements and limitations of each plan**. Each plan has different stipulations regarding how often services may be provided and, even more importantly, where those services may be performed. With this in mind; in order to establish and maintain a physician-patient relationship with our practice, the following terms must be acknowledged by the patient or responsible party (parent, guardian, etc):

Authorization for release of information

I authorize the Westfield Orthopedic Group to release to any medical insurance company, health plan, employer, affiliated entity, or pharmaceutical company records needed to determine responsibility for medical benefits and to obtain reimbursement for professional services rendered or needed. I also authorize the Westfield Orthopedic Group to release to any outside vendor/supplier any medical information needed to obtain authorization for treatment and/or a prescribed supply. I further authorize the WOG to release appropriate medical information to any doctor, hospital, health-care facility, school, employer, pharmacist, case manager or third party administrator that has or will participate in my care.

Professional Fees

I understand that I am financially responsible for any and all charges for professional services, whether or not paid by an insurance carrier or health plan. Exceptions are when patient financial responsibility is limited by statutory regulation (such as an authorized Workers' Compensation claim, Medicare Fee Schedule, Motor Vehicle Fee Schedule or by managed care contracts).

In those instances in which the Doctor is to be paid by my insurance carrier, I

a) Understand that it is my responsibility to pay, at the time of service, any deductible, co-payment, and "non-covered" services (i.e.: items which may not be covered by a particular insurance plan, such as crutches, braces, x-rays, Gortex, splints and canes).
b) Request that payment of authorized medical benefits be made on my behalf and assigned to the Westfield Orthopedic Group, Chartered.
c) I understand that if out-of-network- coverage is applied for any services, I will be responsible for any deductible and or co-insurance.

Disability Forms, Reports, Etc.

Requests for completion of disability forms, reports or other paperwork require a fee, paid in advance. Fees will vary in accordance with the amount of preparation involved. Please allow 5 business days for completion of any forms. If forms are to be mailed, a stamped, self addressed envelope must be provided by patient.

Medical-Legal Reports/ Testimony

I acknowledge this office's policy regarding medical-legal reports and testimony. Upon proper written authorization and prepaid copying/clerical/postage fees, copies of medical records will be provided. The doctors do not testify, nor make court appearances. Permanency evaluations and narrative reports are prepared at their discretion. If this policy is unacceptable to me or my attorney, I am aware that I should seek further orthopedic treatment elsewhere. Records will not be released until the patient's balance is paid in full.

Authorization to treat

I hereby authorize the doctors of the WOG to examine me and to do x-rays or other tests that may be needed to make a diagnosis and to recommend and provide treatment. I consent to necessary office or other outpatient treatment after being informed of alternatives and benefits.

Insurance

a) The patient must provide proof of coverage at the time of each office visit.
b) Any required written authorization/referral must be provided at time of service. I understand that I am responsible for obtaining these referrals and to keep track of the number of visits allowed.
c) Any managed care co-payment is due at the time of each office visit.
d) I understand if I do not have the appropriate authorization/referral, I will assume full financial responsibility for payment for that office visit. Payment must be made at the time of service.
e) I understand that The Westfield Orthopedic Group is unable to call my Primary Care Physician for referrals or verbal authorizations.
f) I understand, if x-rays are taken at the Westfield Orthopedic Group and they are denied for any reason, and not reimbursed, I will assume full financial responsibility for payment of these x-rays.
g) I understand that I will be given the option to purchase supplies directly from the Westfield Orthopedic Group at the time of service, regardless of my insurance coverage **OR** I will be given a prescription to seek alternative venders who may participate with my insurance carrier.
h) I understand it is not the responsibility of The Westfield Orthopedic Group to verify that the physician I have an appointment with participates with my insurance plan. I accept full financial responsibility for all visits with a non-par physician.
i) I understand that if the Westfield Orthopedic Group does not participate with my insurance plan, payment is due at the time of service.

Fail to Show/Cancellation Same Day Appointments
I agree to pay a $50 fee for any missed appointment and a $25 for any appointment cancelled less than 24 hours prior to the appointment time. I agree to pay a $200 fee for any cancelled surgery that is not cancelled 7 days in advance without a valid doctors note. I accept responsibility for any adverse medical consequences resulting from missing a recommended follow-up visit, treatment, or test.

Workers' Compensation/ Motor Vehicle Related Injuries
It is the patient's responsibility to clearly identify those medical injuries/conditions, which he/she believes are motor vehicle related, or work related at the time of the initial visit.

Workers' Compensation Claims
In order for this office to submit claims for medical services, we must receive written (letter or fax) authorization from the employer or the Workers' Compensation Insurance Carrier prior to the initial office visit. The patient is responsible for any charges for professional services, which are denied due to lack of proper authorization. Patient agrees to pay his/her bill in full immediately upon receipt.

Motor Vehicle (PIP) Claims
Insurance claims resulting from Motor Vehicle related injuries must be submitted to your Motor Vehicle (PIP) carrier and cannot be billed to the patient's private insurance unless PIP coverage has been denied, does not exist, or private insurance was selected as the primary carrier. The patient is responsible for any deductibles or co-insurance under their PIP coverage and agree to pay these at the time of service.

X-Rays
The x-rays performed in our office constitute an integral part of the medical records. Fees for x-rays are for the professional services rendered and medical information obtained, and are not to be misconstrued as a purchase of films. Our practice reserves the right to keep all original films, and in such cases will arrange for copying of any requested x-rays for a fee. This request must be made in writing and fees prepaid. Please allow a minimum of 7 business days for x-ray copying. X-rays will not be mailed.

Late Fees
We reserve the right to charge a monthly rebilling fee of $10.00 for any patient balance not paid within 30 days. Additionally, past due bills are subject to interest charges at the rate of 1 ½ % per month (18% per annum).

Cost of Collection
If this account becomes delinquent, I will be responsible for additional billing costs; and if this account is assigned to a collection agency or attorney for collection, this will result in additional costs, including reasonable and necessary attorney's fees for which the patient agrees to be responsible. I acknowledge a fee of $30.00 or the actual bank charge; whichever is greater, for any returned check. Further appointments will not be granted to patients who have accounts in arrears

Disclosure of ownership
Public law of the State of New Jersey requires that a physician, chiropractor or podiatrist inform their patients of any financial interest they may have in a health care service. Accordingly, we wish to inform you that we do have a financial interest in the following health care service: The Center for Ambulatory Surgery. You may seek treatment at a health care facility of your choice. A listing of alternative healthcare services can be found in the classified section of your telephone directory under the appropriate heading.

I authorize a photocopy, facsimile or other electronic transmission of the above authorization to be used in place of the original.

TELEPHONE CONSUMER PROTECTION ACT (TCPA):
You agree, in order for us to service your account or to collect monies you may owe, Westfield Orthopedic Group and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Westfield Orthopedic Group, its employees and/or agents may contact me/us as described above.

_____	_____	_____
Signature of Patient (parent/guardian)	Printed name of Patient (parent/guardian)	Date

By signing this form I agree to all of the above policies.

_____	_____	_____
Signature of Patient (parent/guardian)	Printed name of Patient (parent/guardian)	Date

WESTFIELD ORTHOPEDIC GROUP

PLEASE PRINT LEGIBLY AND COMPLETE ALL INFORMATION

LAST NAME _____ FIRST _____ MI _____ D.O.B. _____ AGE ____ SEX M/F/other MARITAL S-M-W-D

PREFERRED NAME: _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____ SS# _____

HOME PHONE ( ) _____ CELL PHONE ( ) _____ E-MAIL _____

NAME OF EMPLOYER _____ EMPLOYER PHONE NUMBER ( ) _____

EMPLOYER ADDRESS _____

SPOUSE'S NAME _____ SPOUSE'S ADDRESS (IF DIFFERENT) _____

SPOUSE'S PHONE ( ) _____ D.O.B. _____

FAMILY PHYSICIAN _____ PH # ( ) _____

PHARMACY NAME/CITY _____ PH # ( ) _____

REFERRING PHYSICIAN NAME _____ PHONE NUMBER ( ) _____

WHO IS THE INSURED [ ] PATIENT [ ] SPOUSE [ ] MOTHER [ ] FATHER [ ] OTHER

FOR STUDENTS AND/OR MINORS (UNDER 18) THIS SECTION MUST BE COMPLETED IN FULL

MOTHER'S NAME _____ D.O.B. _____ SS# _____ HOME PHONE ( ) _____

STREET ADDRESS _____ CITY, STATE _____ ZIP _____

MOTHER'S EMPLOYER _____

FATHER'S NAME _____ D.O.B. _____ SS# _____ HOME PHONE ( ) _____

STREET ADDRESS _____ CITY, STATE _____ ZIP _____

FATHER'S EMPLOYER _____

IF THIS VISIT IS WORK, AUTO, OR LIABILITY RELATED, PLEASE ADVISE OUR FRONT DESK SO THEY MAY PROVIDE YOU WITH ADDITIONAL REQUIRED PAPERWORK.

DIVORCED PARENTS: IT IS THE POLICY OF THIS OFFICE THAT THE PARENT ACCOMPANYING THE CHILD FOR TREATMENT WILL BE HELD RESPONSIBLE FOR ALL CHARGES.

I authorize the release of any information needed to process this claim. I hereby authorize payment of medical benefits to Westfield Orthopedic Group.

Signature _____ Date _____

PLEASE COMPLETE BOTH SIDES

WESTFIELD ORTHOPEDIC GROUP

ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

Acknowledgement of Practice's Notice of HIPAA Privacy Policy:
I have received a copy of the HIPAA Privacy Notice for the Westfield Orthopedic Group

_____ _____ _____
Name of Patient Signature of Patient/Parent Date

Designation of Certain Relatives, Close Friends and Other Caregivers:
I agree that the Westfield Orthopedic Group may disclose certain portions of my health information to a family member, close personal friend or other caregiver, involved with my health care or payment relating to my health care. The Westfield Orthopedic Group will only disclose information that is directly relevant to the person's involvement with my health care or payment relating to my healthcare

I designate the following persons listed below as persons involved in my healthcare or payment relating to my healthcare. I understand that I am not required to list anyone. I also understand that I can revoke this authorization at any time in writing.

Print Name_____

Print Name_____

Print Name_____

Print Name_____

The following person(s) are not authorized to receive my Patient Health Information:

Print Name_____Print Name_____

Print Name_____Print Name_____

Telephone, Written and Fax Communication

I authorize you to contact me n the following matter:

Home Telephone Number
___OK to leave detailed message
___Leave message with call back number only

Cell Phone
___OK to leave detailed message
___Leave message with call back number only

Fax Communication
___OK to fax

Written Communication
___OK to send mail to my home address
___Ok to send mail to my work/office

Work Telephone Number
___OK to leave detailed message
___Leave message with call back number only

Other_____

PERSONAL HISTORY AND FAMILY HISTORY

Do you or your family members have any of the following conditions?

Condition	You	Family Member	Condition	You	Family Member
Arthritis			Hepatitis		
Asthma			High Blood Pressure		
Cancer			HIV/Aids		
Diabetes			Stroke		
Epilepsy			Tuberculosis		
Heart Disease			Other		

REVIEW OF SYSTEMS

Constitutional	Y	N	Ears/Nose/Throat/Mouth	Y	N	Eyes	Y	N
Recent weight gain/loss			Hearing Loss/ringing			Blurred/double vision		
Night sweats/fevers			Sinus Problems			Eye disease or injury		
Fatigue			Nose bleeds			Glaucoma/Cataracts		
Cardiovascular			**Respiratory**			**Gastrointestinal**		
Chest Pain			Shortness of breath			Nausea/vomiting		
Palpitations			Wheezing/Asthma			Abdominal pain		
Swelling hands/feet			Sleep Apnea			Rectal bleeding		
Musculoskeletal			**Neurological**			**Integumentary (skin/breast)**		
Muscle pain or cramps			Paralysis or tremors			Change in hair or nails		
Stiffness/swelling joints			Convulsions/seizures			Rashes or itching		
Trouble walking			Numbness/tingling			Breast lump		
Endocrine			**Hematologic/Lymphatic**			**Allergic/Immunologic**		
Excessive thirst/urination			Bruise easily			Food allergies		
Thyroid disease			Slow to heal			Animal allergies		
Hormone problem			Enlarged glands			Other		
Genitourinary-Male Only			**Genitourinary-Female Only**			**Psychiatric**		
Blood in urine			Blood in urine			Insomnia		
Kidney Stone			Menstrual problems			Confusion/memory loss		
Testicular pain			Could you be pregnant?			Depression		

Describe any medical information of importance not indicated on this form _____

_____

_____

NOTE: Both doctor and patient is encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above; I acknowledge that my questions if any, about inquiries set forth have been answered to my satisfaction. I will not hold my physician or any other member of his/her staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I will notify the physician should there be any changes to my medical condition.

_____ _____

Signature of Patient/Guardian Date

WESTFIELD ORTHOPEDIC GROUP
PATIENT MEDICAL PROFILE

PLEASE COMPLETE BOTH SIDES

Date_____

Name_____ Occupation_____

Person to call in case of an Emergency_____ Telephone#_____

Reason for visit_____

How and when did start?_____

Was it the result of: ❑ Work Accident? ❑ Car Accident? **Are you right-handed?** ❑ Yes ❑ No

Have you ever been treated for this problem before? ❑ Yes ❑ No If yes, give details_____

Smoking history: Packs/Day_____for_____years ❑ Non-smoker

Alcohol consumption: ❑ Daily ❑ Weekly ❑ Rarely ❑ Never

Have you had any **blood transfusions**? ❑ Yes ❑ No

Do you have any **contagious diseases**? ❑ Yes ❑ No Please specify _____

Have you ever had any **problems/reaction to anesthesia**? ❑ Yes ❑ No

Is there any family or personal history of **blood clots**? ❑ Yes ❑ No Are you taking a **blood thinner/daily aspirin**? ❑ Yes ❑ No

Height_____ Weight (approx.)_____

EXERCISE? ❑ Daily ❑ Weekly ❑ Monthly ❑ Rarely ❑ Never

DESCRIBE **YOUR JOB**: ❑ Homemaker ❑ Desk Job ❑ Light Duty Work ❑ Medium Duty ❑ Heavy Duty

Hobbies/Sports_____

Are you now under the care of another physician? If so, for what condition? _____

ALLERGIES: Are you allergic to or have you had a reaction to: (Please fill out both columns)

Yes	No	Don't Know		Yes	No	Don't Know	
❑	❑	❑	**Local Anesthesia**	❑	❑	❑	**Latex**
❑	❑	❑	**Aspirin**	❑	❑	❑	**Iodine**
❑	❑	❑	**Penicillin**	❑	❑	❑	**Hay fever/seasonal**
❑	❑	❑	**Sulfa Drugs**	❑	❑	❑	**X-ray Dyes**
❑	❑	❑	**Codeine**	❑	❑	❑	**Other**_____

MEDICATION LIST (list everything you take)
(Also include non-prescription medications, such as Advil, Tylenol, and supplements/herbs)

1)	**5)**	**9)**
2)	**6)**	**10)**
3)	**7)**	**11)**
4)	**8)**	**12)**

PAST SURGERIES (list all)

Type of Surgery (list left/right, if applicable)	When performed (approx.)