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. _____ SPOUSE'S SS# _____

SPOUSE'S EMPLOYER _____ EMPLOYER PHONE NUMBER _____

FAMILY PHYSICIAN _____ PH # _____

PHARMACY NAME/CITY _____ PH # _____

REFERRING PHYSICIAN NAME _____ PHONE NUMBER _____

WHO IS THE INSURED **[ ] PATIENT** **[ ] SPOUSE** **[ ] PARENT #1** **[ ] PARENT #2** **[ ] OTHER**

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

PARENT #1 NAME _____ D.O.B. _____ SS# _____ CELL PHONE _____

STREET ADDRESS _____ CITY, STATE _____ ZIP _____

PARENT #1 EMPLOYER _____

PARENT #2 NAME _____ D.O.B. _____ SS# _____ CELL PHONE _____

STREET ADDRESS _____ CITY, STATE _____ ZIP _____

PARENT #2 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. THIS MAY NOT BE ALTERED.

I authorize the release of any information needed to process all claims. 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 in 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_____

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.)

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

THE WESTFIELD ORTHOPEDIC GROUP
PATIENT FINANCIAL POLICY AND AGREEMENT

To provide the highest quality medical care and maintain a professional physician-patient relationship, Westfield Orthopedic Group requests that all patients review and acknowledge the following policies regarding financial responsibility, insurance, billing, and collections.
By signing below, the patient and/or responsible party agrees to the following terms and conditions.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Westfield Orthopedic Group to release medical information necessary to process insurance claims, including claim denials, obtain reimbursement for services rendered, coordinate care, and otherwise administer my treatment and healthcare benefits.
I further authorize payment of medical benefits directly to Westfield Orthopedic Group for services rendered.

PROFESSIONAL FEES

I understand that I am financially responsible for all charges incurred for professional services rendered by Westfield Orthopedic Group, regardless of insurance coverage.
This responsibility includes, but is not limited to:

Deductibles
Copayments
Coinsurance
Non-covered services

Services denied by insurance due to lack of authorization, referral, or failure to meet plan requirements
Any balance determined to be the patient's responsibility by the insurance carrier
Payment is due at the time services are rendered unless prior arrangements have been made.

INSURANCE RESPONSIBILITIES

Patients are responsible for:
Providing current insurance information at each visit.
Obtaining any required referrals or authorizations.
Understanding the limitations of their insurance coverage.
Paying all applicable copayments, deductibles, and coinsurance at the time of service.
Verification of insurance benefits is not a guarantee of payment.
Westfield Orthopedic Group is not responsible for determining whether a physician participates with a specific insurance plan.

MISSED APPOINTMENTS AND LATE CANCELLATIONS

Appointments cancelled less than twenty-four (24) hours before the scheduled appointment time may be subject to a cancellation fee of $50.00.
Patients who fail to appear for a scheduled appointment without notice may be subject to a no-show fee of $75.00.
Scheduled surgical procedures cancelled without at least seven (7) days notice and without a valid medical reason may be subject to a cancellation fee of $200.00.

WORKERS' COMPENSATION AND MOTOR VEHICLE CLAIMS

Our office does not treat any injuries related to work injury or motor vehicle accidents. If patients are seen for this injury, they assume full financial responsibility.

X-RAYS AND MEDICAL RECORDS

X-rays obtained by Westfield Orthopedic Group are part of the patient's medical record.
Copies of x-rays or records may be provided in accordance with applicable state and federal regulations.
Reasonable fees permitted by law may apply.

COST OF COLLECTION

If an account becomes delinquent and is referred to a collection agency or attorney for collection, the patient agrees to be responsible for all costs of collection permitted by law, including:

Collection agency fees of up to thirty percent (30%) of the outstanding balance	Reasonable attorney's fees Court costs Filing fees	Other reasonable expenses incurred in collecting the debt

These amounts may be added to the patient's account balance and shall become immediately due and payable.

RETURNED PAYMENTS

A fee of $35.00 or the maximum amount permitted by law may be charged for any returned check, returned ACH payment, or chargeback not resulting from a billing error.

DISCLOSURE OF OWNERSHIP INTEREST

Pursuant to New Jersey law, Westfield Orthopedic Group hereby discloses that physicians associated with the practice may have a financial interest in:
The Center for Ambulatory Surgery
Patients may seek treatment at any healthcare facility of their choosing.

TELEPHONE, TEXT MESSAGE, AND EMAIL COMMUNICATIONS

To service my account and communicate regarding my medical care, appointments, balances, and insurance matters, I authorize Westfield Orthopedic Group and its agents to contact me by:

Telephone	Text message	Automated dialing systems
Cellular telephone	Email	

Artificial or prerecorded voice messages, where permitted by law
Standard message and data rates may apply.

ACKNOWLEDGMENT

I have read and understood this Patient Financial Policy and Agreement.
I agree to be bound by its terms and conditions.

Patient Name: _____ Patient/Parent signature: _____

Date: _____