CHART #	LAST NAME	FIRST NAME	M.I.	MARITAL STATUS S M W D
DATE OF BIRTH	AGE	SEX M F	HEIGHT FT: IN:	WEIGHT	SS#
ADDRESS				HOME PHONE# CELL #
SPOUSE'S NAME	PARENT'S NAME IF A MINOR		ADDRESS IF DIFFERENT FROM ABOVE	
PATIENT'S EMPLOYER (FATHER'S IF PATIENT A MINOR)			OCCUPATION	
EMPLOYER'S ADDRESS			WORK PHONE #	
SPOUSE'S EMPLOYER (MOTHER'S IF PATIENT A MINOR			OCCUPATION	
EMPLOYER'S ADDRESS			WORK #	
EMERGENCY CONTACT:	PRIMARY PHONE #		SECONDARY PHONE #	
REFERRED BY:				
FAMILY MD:	ADDRESS:		PHONE #	

LIST ANY MEDICATIONS & DOSAGES YOU ARE PRESENTLY TAKING:

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

LIST KNOWN DRUG ALLERGIES:_____

ARE YOU ALLERGIC TO LATEX? YES NO

LIST KNOWN MEDICAL PROBLEMS/PAST SURGERIES

1._____ 4._____

2._____ 5._____

3._____ 6._____

ADDITIONAL INFORMATION:_____

THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY BELIEF

PATIENT'S SIGNATURE_____ DATE:_____

NAME_____ Date_____

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you. **Do you have a history of:**

1. Unexplained weight loss YES___NO___
2. Fever or chills YES___NO___
3. Night sweats YES___NO___
4. Skin rashes YES___NO___
5. Head trauma YES___NO___
6. Frequent headaches YES___NO___
7. Double or blurry vision YES___NO___
8. Hearing loss YES___NO___
9. Ringing in ears YES___NO___
10. Nasal congestion YES___NO___
11. Hoarseness YES___NO___
12. Sore throat YES___NO___
13. Swollen glands YES___NO___
14. Breast masses or lumps YES___NO___
15. Wheezing YES___NO___
16. Shortness of breath YES___NO___
17. Coughing YES___NO___
18. High blood pressure YES___NO___
19. Heart murmur YES___NO___
20. Palpitations YES___NO___
21. Stroke YES___NO___
22. Chest pain YES___NO___
23. Heartburn YES___NO___
24. Heart attacks YES___NO___
25. Congestive heart failure YES___NO___
26. Pacemaker or defibrillator YES___NO___
27. Cardiac stents YES___NO___
28. Abdominal pain YES___NO___
29. Fibromyalgia YES___NO___
30. Stomach/intestinal ulcers YES___NO___
31. Change in bowel habits YES___NO___
32. Urinary frequency YES___NO___
33. Incontinence YES___NO___
34. Thyroid problems YES___NO___
35. Diabetes YES___NO___
36. Hepatitis YES___NO___
37. Muscle weakness YES___NO___
38. Leg swelling YES___NO___
39. Varicose veins YES___NO___
40. Blood clots YES___NO___
41. Anxiety YES___NO___
42. Depression YES___NO___
43. Memory loss YES___NO___
44. Hernias YES___NO___
45. Menstrual problems YES___NO___
46. Bleeding problems YES___NO___
47. Unusual post-op bleeding YES___NO___
48. Anesthesia problems YES___NO___
49. Cancer YES___NO___
50. Malignant hyperthermia YES___NO___
51. HIV OR AIDS YES___NO___
52. Metal in eyes YES___NO___
53. Brain aneurysm clip YES___NO___
54. Cochlear implants YES___NO___
55. Sleep apnea YES___NO___
56. Asthma YES___NO___
57. Do you smoke?_____ Have you ever?_____How much?_____
58. Do you drink alcohol?_____Have you ever?_____How much?_____
59. Recreational drug use?_____Explain_____
60. Does any family member suffer from any medical problems?_____
61. Does any blood relative have a history of malignant hyperthermia or any other anesthesia Problems? YES_____ NO_____
62. Do you have an Advance Directive? YES_____NO_____
63. Females – Did you ever have a bone density test (DEXA) YES_____NO_____ DATE_____
64. Did you get the pneumonia vaccine? YES_____ NO_____Date_____
65. Do you suffer from depression? YES_____NO_____

THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY BELIEF.

_____ _____

PATIENT SIGNATURE **DOCTOR SIGNATURE**

PATIENT'S NAME	***IMPORTANT: YOU MUST HAVE A REFERRAL FOR YOUR APPOINTMENT IF REQUIRED BY YOUR INSURANCE. PLEASE CONTACT YOUR PCP***
PRIMARY INSURANCE_____ ADDRESS_____ _____ GROUP #_____ ID#_____ SUBSCRIBER_____ SUBSCRIBER'S DATE OF BIRTH_____ IS A REFERRAL REQUIRED?_____	SECONDARY INSURANCE_____ ADDRESS_____ _____ GROUP #_____ ID#_____ SUBSCRIBER_____ SUBSCRIBER'S DATE OF BIRTH_____ IS A REFERRAL REQUIRED?_____
IS SCHOOL INSURANCE INVOLVED? YES NO DID YOU FILE A CLAIM WITH THE SCHOOL? YES NO	SCHOOL NAME

***IF THIS VISIT IS COVERED BY WORKMEN'S COMPENSATION OR MOTOR VEHICLE ACCIDENT INSURANCE AND WE WERE NOT INFORMED OF THIS WHEN THE APPOINTMENT WAS MADE, PLEASE CONTACT US IMMEDIATELY AT 610-375-4949

WAS THIS AN AUTO ACCIDENT: YES NO DATE OF ACCIDENT:_____

NAME OF INSURANCE COMPANY_____

MAILING ADDRESS_____

PHONE:_____ CLAIM #_____

ATTORNEY_____ PHONE #_____

WAS THIS A WORK INJURY? YES NO DATE OF ACCIDENT:_____

WERE YOU INJURED ON THE JOB? YES NO WAS THE ACCIDENT REPORTED? YES NO

INSURANCE CARRIER:_____

CONTACT PERSON_____ PHONE #_____

ADDRESS:_____ CLAIM #_____

INSURANCE AUTHORIZATION AND ASSIGNMENT: I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS INCLUDING AUTO, MEDICARE, PRIVATE, WORKER'S COMPSENATION AND OTHER MEDICAL HEALTH PLANS TO WHICH I AM ENTITLED TO BERKSHIRE ORTHOPEDIC ASSOCIATION. I AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THESE BENEFITS AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. THE ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING AND A PHOTO COPY IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

_____ _____

SIGNATURE OF PATIENT (GUARDIAN IF PATIENT IS A MINOR) DATE

BERKSHIRE ORTHOPEDICS , LLC FINANCIAL POLICIES

Regardless of your insurance coverage, you are always responsible for making sure your bill is paid promptly and in full. This office cannot accept responsibility for collecting your insurance claim or negotiating a settlement on a claim. Patients should remember that professional services are rendered and charged to the patient, not to the insurance company. Charges are never contingent upon the outcome of pending lawsuits, insurance disputes, or reimbursement from insurance companies. If your account has an outstanding balance, you will receive a statement each month. Monthly payments are required on accounts.

COPAYMENTS, COINSURANCES, AND DEDUCTIBLES

The patient is expected to present an insurance card at each visit. All co-payments, coinsurances, deductibles and past-due balances are due and payable at check-in. If you cannot pay, you will be asked to reschedule your appointment.

SELF PAY ACCOUNTS

Self-pay accounts are patients who are covered by insurance plans that the office does not participate in, patients without an insurance card on file, patients without referrals or unverified accident cases. It is expected that payment is required at the time of all services including surgeries. Office charges will be collected at check-in.

NON-PARTICIPATING INSURANCE PLANS

The insurance will be billed as a non-assigned claim as a courtesy to the patient, with the patient paying the office the amount in full. The insurance company will reimburse the patient on non-assigned claims.

PATIENT REFUNDS

The following criteria must be met prior to issuing a patient refund: the patient does not have any scheduled appointments, there are no out-standing insurance claims on the patient's account, and there are no out-standing patient balances on the account.

REFERRALS

If your insurance has designated a primary care physician (PCP), you are required to have prior authorization from your PCP prior to your office visit. If this authorization is not provided, you will be asked to reschedule your appointment or pay for the visit at the time of service

CHILD CUSTODY CASES

The parent with primary custody is usually the parent with whom the child lives and who usually brings the child to the office for care. The custodial parent is responsible to pay at the time of the service. If the non-custodial parent carries the insurance on the child the office will bill that insurance company. The office does not get involved with divorce specifics. It is the parent's obligation to work out an agreement themselves or through the court system.

WORKER'S COMPENSATION AND AUTOMOBILE ACCIDENT CASES

We will file your claim to your insurance carrier. All claims must be verified prior to service being rendered. If a claim is not verified, you will be considered a self-pay and payment will be collected at check-in. You will be responsible for your bill if your claim is denied for any reason.

APPOINTMENT CANCELLATION POLICY

We understand if you can't keep an appointment but please call us to notify us. There may be a $35 charge to those who do not call to cancel an appointment.

PAST-DUE ACCOUNTS

Any time a payment is not received during the last 30 days, your account is considered to be past due. If you are having trouble paying your bill, we can arrange a payment plan for you. Accounts more than 60 days past due will be turned over to collection. Unpaid collection accounts could be reported to the credit bureau.

AGREEMENT TO PAY

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, attorney fees, and/or court costs, if such are necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Pennsylvania, and any other State.

CONSENT TO CONTACT

You agree, in order for us to service your account or to collect monies you may owe, BOA 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 us. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices as applicable.

RECORDS RELEASE

I authorize Berkshire Orthopedics, LLC., to release all information necessary to secure payment. This would include all auto, work comp., school insurance and all other insurances. The assignment will remain in effect until revoked by me in writing and a photocopy is to be considered as valid as the original.

This financial policy helps the office provide quality care to our valued patients. If you have any questions please feel free to contact us.

_____

PATIENT SIGNATURE

_____

DATE

Berkshire Orthopedic Associates, Inc.
A division of Keystone Orthopaedic Specialist, LLC.

PATIENT NAME:_____ DATE OF BIRTH:_____

Acknowledgment of Notice of Privacy Practices

Our **Notice of Privacy Practices** provides information about the ways in which we may use and disclose health information about your (for purposes of treatment, payment and health care operations) and describes your rights and our obligations regarding the use and disclosure of that information. Federal regulations require that we give our patients or their authorized representatives our Notice of Privacy Practices before signing this acknowledgment form. In addition, to the copy we may provide you in our office, our Notice of Privacy Practices is posted in our waiting room.

By signing this form, I am acknowledging that I have been offered and/or received a copy of Berkshire Orthopedic Associates, Inc. Notice of Privacy Practices.

_____ _____
Patient's signature (or authorized Personal Representative's signature & printed name) Date

For Office Use Only: A good faith effort was made to obtain the patient's acknowledgment of the receipt of the Notice of Privacy Practices. The following explanation identifies the reason the acknowledgment was not obtained:

_____ _____ _____
Explanation Signature of Staff Member Date

Authorization of Verbal Release of Protected Health Information

According to federal privacy regulations, the release of your protected health information is permitted only for reasons as described in the Notice of Privacy Practices, or as otherwise allowed by the **specific signed authorization** of the patient or authorized personal representative.

I authorize the physician and staff of Berkshire Orthopedic Associates, Inc to discuss my health information with the following person (s).

Name/Relationship_____phone #_____

Name/Relationship_____phone #_____

Name/Relationship_____phone #_____

Or ◯ **I decline, do not discuss my care with anyone other than as allowed by federal regulations.**

*Please note that certain information cannot be released without specific authorization as required by state or federal law. This includes the following: information regarding the patient's diagnosis and treatment for HIV/AIDs, psychotherapy notes from a Psychiatrist o Psychotherapist and treatment for alcohol or drug abuse reports.

You may write us a letter cancelling your authorization at any time. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

By signing, I am authorizing the physician and staff of Berkshire Orthopedic Associates, Inc, to speak to the person (s) noted above on my behalf about my health information.

_____ _____
Patient's Signature (or Authorized Personal Representative's Signature and Printed Name) Date

This authorization will expire 3 years from the date of signing. This form is not valid unless signed and dated.

TURN OVER ⟶

This authorization permits BOA to use and/or disclose the following health information about me. Please read the selections carefully and check only the boxes that apply.

A ☐ BOA staff may leave messages on answering machine/voice mail with confidential message (i.e. apt reminders, normal test results, medications and other treatments).

This call may be placed to my cell phone ☐ home phone ☐ work phone ☐

B ☐ BOA may leave messages on an answering machine with another person as specified/named above about apts, normal tests results, medications and other treatments.

The following statement means that we will not share any information with any person other than you. YOU SHOULD NOT CHECK THIS IF YOU HAVE CHECKED IF YOU HAVE CHECKED SECTION B & LISTED NAMES ABOVE.

C ☐ I do not want any protected health information shared with others.