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___	29. Fibromyalgia	YES___ NO___
2. Fever or chills	YES___NO___	30. Stomach/intestinal ulcers	YES___NO___
3. Night sweats	YES___NO___	31. Change in bowel habits	YES___NO___
4. Skin rashes	YES___NO___	32. Urinary frequency	YES___NO___
5. Head trauma	YES___NO___	33. Incontinence	YES___NO___
6. Frequent headaches	YES___NO___	34. Thyroid problems	YES___NO___
7. Double or blurry vision	YES___NO___	35. Diabetes	YES___NO___
8. Hearing loss	YES___NO___	36. Hepatitis	YES___NO___
9. Ringing in ears	YES___NO___	37. Muscle weakness	YES___NO___
10. Nasal congestion	YES___NO___	38. Leg swelling	YES___NO___
11. Hoarseness	YES___NO___	39. Varicose veins	YES___NO___
12. Sore throat	YES___NO___	40. Blood clots	YES___NO___
13. Swollen glands	YES___NO___	41. Anxiety	YES___NO___
14. Breast masses or lumps	YES___NO___	42. Depression	YES___NO___
15. Wheezing	YES___NO___	43. Memory loss	YES___NO___
16. Shortness of breath	YES___NO___	44. Hernias	YES___NO___
17. Coughing	YES___NO___	45. Menstrual problems	YES___NO___
18. High blood pressure	YES___NO___	46. Bleeding problems	YES___NO___
19. Heart murmur	YES___NO___	47. Unusual post-op bleeding	YES___ NO___
20. Palpitations	YES___NO___	48. Anesthesia problems	YES___NO___
21. Stroke	YES___NO___	49. Cancer	YES___NO___
22. Chest pain	YES___NO___	50. Malignant hyperthermia	YES___NO___
23. Heartburn	YES___NO___	51. HIV OR AIDS	YES___NO___
24. Heart attacks	YES___NO___	52. Metal in eyes	YES___NO___
25. Congestive heart failure	YES___NO___	53. Brain aneurysm clip	YES___NO___
26. Pacemaker or defibrillator	YES___NO___	54. Cochlear implants	YES___NO___
27. Cardiac stents	YES___NO___	55. Sleep apnea	YES___NO___
28. Abdominal pain	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_____

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.

I_____ give permission for BOA to give medical treatment.
I have the right to refuse any procedure or treatment.
I have the right to discuss all medical treatments with my clinician.

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian Signature Date

Berkshire Orthopedics LLC

HIPAA Compliance Patient Consent Form / Notice of Privacy Practices

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's right section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. Our HIPAA notice is posted in the waiting room and will provide you a copy upon your request.

The terms of this notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information (PHI) is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your PHI and acknowledge that you have been offered a copy of Notice of Privacy Practices. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that: PHI may be disclosed or used for treatment, payment or healthcare operations. The practice reserves the right to change the privacy policy as allowed by law. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.

Please read the selections and check all that apply:

_____Staff may leave messages on answering machines (i.e. appt reminders, test results, medications, and other treatments)

_____cell phone _____home phone _____work phone

May we discuss your medical condition with any family member / friend? YES NO

If yes, Please list name/relationship and phone number below (list additional names on back)

I authorize the physician and staff to discuss my health information with the following person(s):

1. _____

2. _____

This consent was signed by: (PLEASE PRINT NAME) _____

_____ _____

SIGNATURE DATE