SHASTA ORTHOPAEDICS & SPORTS MEDICINE PATIENT REGISTRATION

PLEASE PRINT & COMPLETE ALL PORTIONS Today's Date Mo. _____ Day _____ Year _____ Chart No _____

PRIMARY CARE PROVIDER _____ HAVE YOU EVER BEEN TREATED BY ONE OF OUR DOCTORS? ☐ Yes ☐ No

BODY PART TO BE TREATED _____ REFERRED BY _____
Physician, Attorney, Other

PATIENT NAME _____ Gender _____ DATE OF BIRTH _____ AGE _____

MAILING ADDRESS _____ HOME PHONE _____
Street or Box Number City State Zip

SOCIAL SECURITY # _____ E-MAIL _____

MARITAL STATUS (check one) ☐ Married ☐ Unmarried ☐ Separated ☐ _____

PATIENT'S EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ EMPLOYER'S PHONE _____
Street or Box Number City State Zip

PRIMARY INSURANCE_____MEMBER ID_____ GROUP ID_____

PRIMARY INSURANCE ADDRESS _____
Street or Box Number City State Zip

SUBSCRIBER NAME _____SUBSCRIBER DATE OF BIRTH _____

SECONDARY INSURANCE _____MEMBER ID_____GROUP ID_____

SECONDARY INSURANCE ADDRESS _____
Street or Box Number City State Zip

SUBSCRIBER NAME_____SUBCRIBER DATE OF BIRTH _____

GUARANTOR/GUARDIAN_____ DATE OF BIRTH _____ OCCUPATION _____

GUARANTOR/GUARDIAN EMPLOYER _____ EMPLOYER'S PHONE _____

ADDRESS _____
Street or Box Number City State Zip

GUARANTOR/GUARDIAN ADDRESS IF DIFFERENT FROM PATIENT'S ABOVE

_____ PHONE _____
Street or Box Number City State Zip

INJURY ☐ Yes ☐ No If yes, complete the following

DATE OF INJURY _____ DID INJURY OCCUR ON THE JOB? ☐ Yes ☐ No

IF NO, WHERE DID INJURY OCCUR? _____

HOW DID IT HAPPEN? _____

EMPLOYER AT TIME OF INJURY _____

EMPLOYER'S WORKER'S COMPENSATION INSURANCE CARRIER _____

ADDRESS COMPENSATION INSURANCE CARRIER _____
Street or Box Number City State Zip

Claim No _____ Adjuster Name _____

PATIENT NOTIFICATION DISCLOSURE OF OWNERSHIP

It is necessary to disclose that doctors at Shasta Orthopaedics & Sports Medicine have a financial interest in the healthcare facilities listed below:

APOGEE OUTPATIENT SURGURY CENTER: Paul E Schwartz, MD; John C Lange, MD; Stephen P Ferraro, Jr, MD, J David Schillen, MD; Farzad H Sabet, MD; Troy A Miles, MD

LIBERTY PHYSICAL THERAPY & SPORTS PERFORMANCE and SHASTA ORTHOPAEDICS MRI: Paul E Schwartz, MD; John C Lange, MD; Stephen P Ferraro, Jr, MD; J David Schillen, MD; Farzad H Sabet, MD; Tony L Chang, MD; Eric J Jenkinson, MD; Troy A Miles, MD; Aaron G Osborne DO; Matthew K Paul, MD; Forrest R Monroe, MD; Jason D Nowak, DPM

MERCY OUTPATIENT SURGERY CENTER: Jason D Nowak, DPM; Aaron G Osborne, DO; Mathew K Paul, MD

SHASTA ORTHOPAEDICS & SPORTS MEDICINE and LIBERTY PHYSICAL THERAPY FINANCIAL POLICIES

The clinical providers, physical therapists, and technical staff at Shasta Orthopaedics & Sports Medicine and Liberty Physical Therapy provide professional, medical, and radiology services required for your orthopedic medical needs, and bill ***only*** for these services and supplies. Services provided by the hospital, surgical center, laboratory, pathologist, anesthesiologist, medical equipment supplier, and in some instances the assisting surgeon are billed separately. Your insurance carrier will be billed for services rendered which requires that we have current information about you, your insurance carrier, and your employer. Shasta Orthopaedics & Sports Medicine employs fellows and non-physician extenders. These licensed healthcare professionals may be involved in your care and treatment. For additional information please visit www.shastaortho.com.

Medicare
Shasta Orthopaedics & Sports Medicine and Liberty Physical Therapy are Medicare Participating Providers. As a participating provider we bill Medicare directly for you and honor the Medicare "allowance". Secondary insurance will be billed if you provide us with that information. You will be required to pay only the amount Medicare determines to be your responsibility not covered by your secondary insurance. You will be sent a statement that details all charge and payment activity.

Partnership HealthPlan and Medi-Cal
Shasta Orthopaedics accepts the Partnership HealthPlan and Medi-Cal allowance. You will be responsible to pay only the amount determined by Medi-Cal to be your share of cost. It is necessary that you pay your share of cost in full at the time service is rendered. Liberty Physical Therapy currently does not accept Partnership HealthPlan and Medi-Cal coverage. Feel free to discuss options for physical therapy services with your physician.

PPO, Indemnity Insurance and HMO Plan
Prior to surgery you will be notified of eligibility and an estimate of benefits (EOB), and all deductible, co-pay and co-insurance amounts will be due at that time. Actual benefits can only be determined when your insurance company processes your bill. You will receive a prompt refund should your payment exceed the actual cost; conversely you are obligated to pay any balance owed. You will receive a statement detailing all charge and payment activity. In the event you or your insurance carrier does not pay within sixty-days of your surgery, Shasta Orthopaedics and Liberty Physical Therapy may be required to seek payment from you. Please assist with this process by notifying your insurance carrier to ensure their financial obligation is met.

Worker's Compensation Insurance
Shasta Orthopaedics and Liberty Physical Therapy accept patients with worker's compensation claims. It is necessary that you provide accurate information about yourself, your injury, your employer, and carrier. Prior to service we will obtain your claim number and pre-authorization from your worker's compensation carrier. You will not receive a bill for services unless your claim is denied and determined *not work related,* whereupon your private insurance will be billed.

Uninsured
You will be responsible for to pay for services rendered in full at the time of service. Please establish yourself as cash pay prior to your appointment date.

Third Party & Liens
Shasta Orthopaedics & Sports Medicine and Liberty Physical Therapy ***do not*** accept third party or lien claims. You will be responsible to pay for services rendered in full at time of service. As a courtesy, Shasta Orthopaedics will provide you with a claim form to submit to your third-party payer.

Forms Completion Fee
Shasta Orthopaedics & Sports Medicine and Liberty Physical Therapy may require that one of our representatives completes insurance or disability forms on your behalf. The form completion fee is $5.00 per page; double-sided is considered two pages with a min charge of $15.00. All forms will be completed within seven (7) business days of receipt of your payment. If copies are required, any applicable record copy fees will be charged in addition to the form completion fee.

Canceled or Missed Appointments
Please contact Shasta Orthopaedics (530) 246-2467 or Liberty Physical Therapy reception at (530) 319-4123 if you are unable to keep your appointment. Missed appointments without proper notice are subject to a Canceled or Missed Appointment fee which will NOT be billed to your insurance carrier. The following table lists appointment types and the length of prior notice required to avoid a charge.

Appointment Type	**Required notice of cancellation**	Charge for cancelled without required notice or missed (*no- show)* appointment
Office Visits/Consultation	1 full business day	$35.00
EMG/NCS Studies	3 full business day	$150.00
Injections and Surgeries	5 full business day	$150.00
Physical Therapy Initial Evaluation	1 full business day	$40.00
Physical Therapy Follow up Treatment	1 full business day	$25.00
MRI or Arthrogram	1 full business day	$250.00
Licensed Clinical Social Worker Initial Evaluation	1 full business day	$150.00
Licensed Clinical Social Worker Follow up Evaluation	1 full business day	$145.00

Credit Card Processing Fee
Shasta Orthopaedics and Liberty Physical Therapy assess a 4% fee on payments made by credit card. This is less than what the practice is charged for credit card payments. There is no fee for payments made by debit card or check.

Non-Sufficient Funds, Cancelled or Returned Checks
Shasta Orthopaedics and Liberty Physical Therapy will assess a fee of $25.00 for each non-sufficient fund transaction, canceled, or returned check. Please call the billing office at **(800) 727-5662** if you have questions about your bill.

Authorization to Release Information and Assignment of Insurance Benefits
My signature on this form gives lifetime authorization for payment of insurance benefits to be made directly to Shasta Orthopaedics & Sports Medicine and assisting physicians for services rendered, and I authorize Shasta Orthopaedics & Sports Medicine to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether they are covered by insurance or not. In the event of a default judgement, I agree to pay all costs of collection and reasonable attorney's fees.

IMMOBILIZATION DEVICE WARNING

Depending on the nature of your condition, it may be necessary for your healthcare provider to prescribe an immobilization device, such as (but not limited to) a brace, splint, cast, sling, etc. Immobilization devices compromise range of motion, impair movement, and can adversely affect reflex time. Your signature on this form acknowledges the doctors at Shasta Orthopaedics strongly advise against the operation of a motor vehicle or any power equipment while wearing an immobilization device as this could result in injury or death. The doctors cannot make any determination regarding the safe operation of a motor vehicle while wearing an immobilization device. Legal determination of your ability to drive safely while wearing an immobilization device can be tested by an appropriately trained licensing authority, most typically the local Department of Motor Vehicles or Department of Transportation.

NOTICE OF PRIVACY PRACTICES

Protected health information (PHI) is the information created and obtained by Shasta Orthopaedics & Sports Medicine while providing services to you. This may include documentation of your symptoms, physical examination, test results diagnosis, treatment, and future care or treatment plans. It also includes documentation necessary to bill for those services. The *Notice of Privacy Practices* explains the federal HIPAA Privacy Rule designed to help protect the privacy of your PHI and details how Shasta Orthopaedics may legally use your health information. The *Notice of Privacy Practices* is posted on the wall in the waiting areas, and a printed copy is available upon request. Additionally, the *Notice of Privacy Practices* is available for download from the Shasta Orthopaedics website at www.shastaortho.com. From the Shasta Orthopaedics Home page select: For Patients, Registration Forms, Learn More, *Notice of Privacy Practices*. If you have any questions about the HIPPA Privacy Rule or navigating the website, please contact Gary Whiteaker at (530) 246-2467.

My signature below acknowledges that I have read, understand, and agree to the following

- **Disclosure of Physician Ownership**
  I do not object utilizing health care services provided by any of the physicians at Shasta Orthopaedics & Sports Medicine who have a financial interest in Liberty Physical Therapy, Apogee Outpatient Surgery Center, or Mercy Outpatient Surgery Center. I understand that I have the right to select a different healthcare provider at any time.
- **Terms of the Shasta Orthopaedics Liberty Physical Therapy Financial Policy and Authorization to Release Information and Assignment of Insurance Benefits**
- **Immobilization Device Warning**
- **Medication History**
  I agree to allow my healthcare provider at Shasta Orthopaedics & Sports Medicine access to my medication history from all medical providers involved in my care.
- **Location, accessibility, and content of *HIPPA Notice of Privacy Practices***
  I understand that Shasta Orthopaedics is permitted by federal privacy laws to make use of and disclose my health information for purposes of treatment, payment, and healthcare operations.
- **I agree that a photocopy of this agreement shall be as valid as the original.**

☐ I authorize representatives of Shasta Orthopaedics & Sports Medicine to leave messages on
☐ **landline** ☐ **cell** ☐ **work** number regarding appointments, test results, billing questions, etc.

☐ My health information is **NOT** to be released to anyone (except under the terms in the Notice of Privacy Practices).

I authorize representatives of Shasta Orthopaedics to discuss my health information with the following individuals:

Name of Authorized Representative (PRINT)	Relationship	Phone Number	✓ for emergency contact only

SIGNATURE OF PATIENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR **DATE**

NAME OF PATIENT OR LEGAL GUARDIAN (PRINT) **DATE**