

**SHASTA ORTHOPAEDICS & SPORTS MEDICINE REGISTRATION FORM**

Today's Date \_\_\_\_\_ Referred by \_\_\_\_\_ Primary Care Provider \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_

**Gender at Birth**  Male  Female **Gender Identity**  Male  Female  Non-binary

**Race**  White  American Indian or Alaska Native  Asian  Black or African American  Native Hawaiian or Pacific Islander

**Ethnicity**  Hispanic or Latino  Not Hispanic or Latino **Other Race** \_\_\_\_\_

Preferred Language  English  Spanish Other language \_\_\_\_\_ Translator Required  Yes  No

Email address \_\_\_\_\_

Physical Address \_\_\_\_\_  
*Street Number and Name City State Zip*

Mailing Address (if different) PO Box \_\_\_\_\_ PMB \_\_\_\_\_  
*City State Zip*

Cell Phone \_\_\_\_\_ Landline \_\_\_\_\_ Work Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Body part to be treated \_\_\_\_\_

Have you been treated at Shasta Orthopaedics in the past?  Yes  No

Are you here for an injury?  Yes  No If yes, date injury occurred \_\_\_\_\_

Did your injury occur on the job?  Yes  No Is your injury sports related?  Yes  No

How did your injury occur? \_\_\_\_\_

If work related, employer at time of injury \_\_\_\_\_

Employer's worker compensation carrier \_\_\_\_\_

Claim number \_\_\_\_\_ Adjuster's name \_\_\_\_\_

**GUARANTOR OR GUARDIAN (Parent of minor child, spouse, or legal representative)**

Relationship to patient  Parent  Guardian  Power of Attorney Other \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Date of birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Physical Address \_\_\_\_\_  
*Street Number and Name City State Zip*

Mailing Address (if different) PO BOX \_\_\_\_\_ PMB \_\_\_\_\_  
*City State Zip*

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

## SHASTA ORTHOPAEDICS & SPORTS MEDICINE and LIBERTY PHYSICAL THERAPY FINANCIAL POLICIES

The clinical providers, fellows, physical therapists, and technical staff at Shasta Orthopaedics & Sports Medicine and Liberty Physical Therapy provide professional, medical, and radiology services and bill only for those services and supplies. Services at the hospital, surgical center, laboratory, or medical equipment supplier, provided by the radiologist, pathologist, anesthesiologist, and in some cases the assisting surgeon, are billed separately to your insurance carrier.

### Medicare

Shasta Orthopaedics & Sports Medicine and Liberty Physical Therapy are Medicare providers and bill the Medicare *allowed charges*. Your secondary insurance will be billed if you provide that information. You must pay the amount not covered by your secondary insurance. You will receive a statement that details all charges and payment activity.

### Partnership HealthPlan and Medi-Cal

Shasta Orthopaedics accepts the Partnership HealthPlan and Medi-Cal allowance. Medi-Cal will decide your share of cost which must be paid in full at the time of service. Liberty Physical Therapy currently does not accept Partnership HealthPlan and Medi-Cal coverage.

### PPO Indemnity Insurance and HMO Plan

Prior to surgery you will receive an estimate of benefits (EOB), and all deductible, co-pay and co-insurance amounts will be due at that time. You will receive a prompt refund should your payment exceed the actual cost. You will receive a statement detailing all charges and payment activity, and you will be responsible for paying any balance owed. In the event you and/or your insurance carrier do not pay within sixty days of your surgery, Shasta Orthopaedics and Liberty Physical Therapy may seek payment from you. Actual benefits are decided by your insurance carrier. Please aid 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. You must provide correct demographic information, including your social security number, injury, and employer. 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/Cash Pay

Payment in full is required at the time of service. Please set up Cash Pay arrangements when you schedule your appointment. You will receive an estimate for the total cost of services prior to treatment.

### Third Party & Liens

Shasta Orthopaedics & Sports Medicine and Liberty Physical Therapy **do not** accept third party or lien claims. You are responsible for paying the full amount at the time of service. As a courtesy, Shasta Orthopaedics will provide you with a form that you can use to submit a claim to your third-party payer.

### Authorization to Release Information and Assignment of Insurance Benefits

Your signature on this form authorizes lifetime payment of insurance benefits to be made directly to Shasta Orthopaedics & Sports Medicine and the attending physicians and authorizes the release of all information necessary to secure payment of benefits.

### Medical Records and Forms

Notes from your visits and other documentation in your chart can be downloaded at no charge from the online Patient Portal. If you don't receive login information, ask a receptionist, or call the office and ask for the Medical Records Department. Copies of your medical records are available within 3 business days of receipt of a valid authorized request and require a cost-based production fee pursuant to HIPPA regulations. Shasta Orthopaedics & Sports Medicine and Liberty Physical Therapy may require a representative to complete insurance or disability forms on your behalf. The fee to complete forms is \$5.00 per page; double-sided is considered two pages with a minimum charge of \$15.00. Forms are processed within seven (7) business days upon receipt of payment. There is a processing fee for copies.

### Physician Payments in Compliance with the Sunshine Act

As of 1/1/2023 all physicians must provide written notice to their patients about the Open Payments federal database, a tool used to search payments made by drug and device companies to physicians and teaching hospitals. Information can be found at <https://openpaymentsdata.cms.gov>. The act requires that detailed information about payment of value over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made to the public.

### **Immobilization Device Warning**

As part of your treatment, you may be prescribed an immobilization device, such as (but not limited to) a brace, splint, cast, sling, etc. Immobilization devices compromise range of motion, impair movement, and may adversely affect reflex time. Your signature acknowledges that doctors at Shasta Orthopaedics strongly recommend 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 at Shasta Orthopaedics do not decide if it is safe to drive a motor vehicle while wearing an immobilization device. Legal determination of your ability to drive safely while wearing an immobilization device can be evaluated by an appropriately trained licensing authority, most typically the Department of Motor Vehicles.

### **Notice of Privacy Practices**

Protected health information (PHI) is information obtained and created by Shasta Orthopaedics & Sports Medicine and may include documentation of your symptoms, physical exam, test results, diagnosis, treatment, and treatment plans, including documentation necessary to bill for services. The *Notice of Privacy Practices* explains federal HIPAA Privacy Rules for the protection and 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: <https://shastaortho.com/patient-center/patient-registration-forms/> For questions about the HIPAA Privacy Rule or navigating the Shasta Orthopaedics website, please contact Gary Whiteaker at (530) 246-2467.

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

- **Location, accessibility, and content of HIPPA Notice of Privacy Practices** – I understand that my health information is protected, and furthermore federal privacy laws allow Shasta Orthopaedics to make use of and disclose my health information for purposes of treatment, payment, and healthcare operations.
- **Authorization to release information and assignment of insurance benefits** – I am financially responsible for all charges not covered by my insurance. In case of a default judgement, I agree to pay all costs of collection and reasonable attorney's fees.
- **Use of anonymous images for educational/promotional purposes** – I acknowledge and authorize SOSM to use deidentified, anonymous, diagnostic images such as x-ray, MRI, or CT scans, pictures and other images or likenesses in presentations for educational/promotional purposes.
- **I acknowledge receipt of the Immobilization Device Warning.**
- I acknowledge receipt of information regarding the **Physician Payments Sunshine Act** and the Open Payments Database.
- **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.
- I acknowledge receipt and signature on the **Shasta Orthopaedics Addendum to Disclosures and Terms**
- *I agree that a signed photocopy of this agreement shall be as valid as the original.*

I authorize representatives of Shasta Orthopaedics & Sports Medicine to leave voice messages about my healthcare information such as appointments, test results, and billing questions at the following numbers:

cell       landline       work

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	✓ emergency contact only
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

SIGNATURE OF PATIENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR

DATE

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NAME OF PATIENT OR LEGAL GUARDIAN (PRINT)

DATE