Orthopaedic & Reconstructive Center
1044 S.W. 44th St Oklahoma City, OK 73109 Ste. 600

PH: 405-631-4263 FAX: 405-616-2670

Patient Account #	APP Date	Provider	
Last name	**First name**	**Middle initial**	❑ **Male** ❑ **Female**
Address	**City**	**State**	**Zip**
Home phone	**Work/Alternate phone**	**Cell phone**	
Email address		**DOB**	
Marital Status ❑ *Married* ❑ *Separated* ❑ *Single* ❑ *Divorced* ❑ *Widowed*		**Social Security Number:**	
Name of employer			
Employer's address	City	State	Zip
Emergency contact	Relationship	**Phone**	
Address	City	State	Zip

Race: _____ **Ethnicity:** _____ **Preferred Language:** _____

How did you hear about us?_____**Who is your Primary care Provider**?_____

Are you the legal guardian or parent of this minor patient? If yes, provide Name, DOB, SS#_____

_____

Your street address if different from patient? _____

Primary Insurance Information

_____
Insurance Carrier

_____
Member/Insured ID Group #

_____
Policy Holder Name Last First Initial

_____
Policy Holder DOB / SS # ___M ___F

_____
Employer Phone #

Secondary Insurance Information

_____
Insurance Carrier

_____
Member/Insured ID Group #

_____
Policy Holder Name Last First Initial

_____
Policy Holder DOB / SS # ___M ___F

_____
Employer Phone #

Insurance Authorization And Assignment

I request that payment of benefits be made on my behalf to ORC/COAPMS for any services furnished to me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply (if applicable). I authorize any holder of medical of other information about me to release to the Social Security Administration and Health Care Financing Administration or it's intermediaries or carriers any information needed for this or any related Medicare/other insurance company claim. I permit a copy of this authorization to be used in place of the original and request payment of the medical insurance benefits be paid to the party who accepts assignment. Any overpayment will be applied to any outstanding balance within ORC/COAPMS." I understand that it is mandatory to notify the healthcare provider. I have answered the questions and have read and understand the terms of assignment and release of information. I promise to pay for services rendered.

Patient or Legal Guardian signature:_____Date:_____

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If the injuries or symptoms you have are the result of a Motor Vehicle Accident or Workers Compensation Case please contact our office. We need to obtain some information prior to scheduling your appointment. Call (405) 631 4263

ACCIDENT QUESTIONNAIRE

Is your chief complaint the result of an accidental injury? YES NO

If yes, date of injury? _____

Where did the accident occur? _____
_____
_____
_____

Describe how the accident occurred (give accident details): _____
_____
_____
_____

Have you filed a claim regarding this injury with any of the following?

Workers' Compensation _____
Motor Vehicle Insurance _____
Company _____
Homeowners _____
(Complete appropriate form)

If not, do you plan on filing a claim in the future? YES NO

Have you sought the advice of an attorney? YES NO

If yes, what is the attorneys' name, address, phone #: _____
_____
_____
_____

Patient or Legal Guardian Signature: _____

Print name: _____ **Date:**_____

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NOTICE TO PATIENTS

Privacy Notice:
This document is the ORC/COAPMS Center Notice of Privacy Practices. Please print and sign your name below to acknowledge that you have received a copy of our Privacy Notice at the date and time indicated below. If you have any questions about our Privacy Practices please contact:

Privacy Officer
Orthopaedic and Reconstruction Center
Central Oklahoma Anesthesia and Pain Management Services
1044 SW 44th Street
Oklahoma City, OK 73109
405-631-4263

Disclosure of Physician Ownership

As a patient of Orthopaedic and Reconstruction Center, we are pleased to inform you of the following:

1 Orthopedic & Reconstructive Center, OneCore Health, The Therapy Center, Towerday Surgery Center, Orthopaedic & Reconstructive Research Foundation, Central Oklahoma Anesthesia and Pain Management Services, Southwest Open MRI may be either fully or partially owned by your physician. (Soo & Frazier)

2. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than those listed above.

3. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

Printed Name: _____
Patient or Legal Guardian Signature: _____
Witness: _____
Date and time Notice Obtained: _____

Orthopaedic and Reconstructive Center

REQUEST FOR CONFIDENTIAL COMMUNICATION AND LIMIT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

NOTICE: THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA) ALLOWS YOU TO REQUEST THAT WE COMMUNICATE WITH YOU ABOUT YOUR PHI IN A WAY THAT IS CONFIDENTIAL. PLEASE USE THIS FORM TO DESCRIBE THE LIMITATIONS ON USE AND DISCLOSURE THAT YOU ARE REQUESTIONG. AS STATED IN THE LAW, WE ARE NOT REQUIRED TO HONOR YOUR REQUEST. IF WE AGREE TO HONOR YOUR REQUEST, WE WILL COMPY WITH YOUR REQUEST UNLESS THE INFORMATION IS NEEDED TO PROVED EMERGENCY TREATMENT, PAYMENT, OPERATIONS, AND IF LEGALLY REQUIRED BY APPLICABLE FEDERAL OR STATE LAW.

PATIENT NAME:_____
BIRTH DATE:_____**SS#**_____

PATIENT REQUEST FOR RESTRICTION OR DIRECT RESTRICTION

(PLEASE CHECK THE APPLICABLE SECTION, FILL IN THE REQUESTED DETAIL, SIGN AND DATE THIS REQUST.)

_____**SPECIFIC RECEIVERS:**

BESIDE YOUR DOCTORS, LIST PEOPLE YOU WOULD LIKE TO HAVE PERMISSION TO RECEIVE YOUR PROTECTED HEALTH INFORMATION.

NAME:_____RELATION:_____

NAME:_____RELATION:_____

NAME:_____RELATION:_____

NAME:_____RELATION:_____

_____**PROHIBIT ALL RECEIVERS:**

IF THIS LINE IS CHECKED, I REQUEST THAT YOU DO NOT DISCLOSE ANY OF MY PHI TO ANYONE INCLUDING FAMILY AND FRIENDS (EXCLUDING INFORMATION AND DISCLOSURES NECESSARY FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATION.)

I CERTIFY THAT I AM OVER 18 YEARS OF AGE AND ACKNOWLEDGE THAT AN EXPLANATION HAS BEEN PROVIDED TO ME OF HOMW MY PHI IS USED AND DISCLOSED. I UNDERSTAND THAT I MAY CHANGE THIS LIMITATIONS OF USE AND DISCLOSURE AT A FUTURE TIME. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR PROVIDING THE CORRECT CONTACT INFORMATION, OR IF LATER CHANGED, I WILL REPORT THE CHANGE.

_____ _____

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN **DATE**

Orthopeadic & Reconstructive Center, P.C.
Financial Policy

The intent of this agreement is to establish an understanding between the office/physicians of Orthopeadic & Reconstructive Center and the patients and/or guarantors regarding finances, and account balances. Please read the following:

- **For Patients With Insurance:** We bill most insurance carriers for you, if proper paperwork is provided to us. You must provide our office with a copy of your insurance card at your initial appointment or you will be responsible for all charges at the time of service. If your insurance changes, you must provide our office with an updated copy of your insurance card in order to ensure our office has a contract with your new insurance carrier as well as to prevent denials. We will also bill most secondary insurance carriers. Since your agreement with your insurance carrier is a private one, **Co-payments and Deductible** are due at the time of service. **Medicare Patients**: We will bill Medicare for you. We will also bill secondary insurance carrier for you. All Co-payments or deductibles are due and payable at the time of service.
- **Surgery Fees:** All co-pays, deductibles and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier which our office will obtain prior to scheduling your surgery.
- **Non-covered Services**: Any care not paid for by your existing insurance coverage will require payment in full at the time of service.
- **Personal Injury Cases**: This office does in some cases, bill for auto accident or other liability or lawsuit related cases. Prior to your appointment, we will need the auto insurance/3rd party liability insurance information, including liable party, mailing address for claims, telephone number, claim/policy number and date of injury. If you are represented by an attorney, we will need your attorney name, address and phone number. We will file a lien on any services rendered to you, however, if your case is not settled, in a timely manner, you will be responsible for payment in full
- **Worker's Compensation**: If your injury is work-related, we will need the case number, insurance carrier name, adjustor name, telephone number and date of injury, prior to your visits, to obtain authorization to treat and bill the worker's compensation company for all charges incurred in our office. If your case is pending or NOT authorized, you are responsible for all charges until a determination has been made regarding your case.
- **Missed Appointments**: In fairness to other patients and the doctor we request that at least 24 hours to cancel appointments. If miss appointments become excessive, you will be a assessed a 'no-show' fee.
- **Special Forms/Disability Forms/Accident Forms**: There will be a charge for all forms to be filled out on behalf of the patient. Payment is required when forms are dropped or, faxed to our office or mailed to our office. Forms will not be completed until payment is made. Our office will quote you a price after reviewing the form. This is a $30 flat fee.
- **Letters/Narratives**: Any patient request for a "special letter" or 'narrative" on their behalf will be charged a flat rate of $750. Narrative in excess of 6 pages will charged an additional $150 per page. Payment for these requests are due five days prior to being dictated. This type of correspondence will not be dictated until payment is received.

Upon signing this agreement, you understand all above information and are responsible for maintaining cooperation with this agreement. If you have any questions/concerns, please express those prior to signing this agreement.

X _____ _____

Patient Signature Date of Signature