



Welcome To Our Office!

**PATIENT REGISTRATION – MINOR**

**\*PLEASE PRINT\***

THE FOLLOWING INFORMATION IS VERY IMPORTANT TO YOUR HEALTH. PLEASE TAKE THE TIME TO FULLY AND ACCURATELY FILL OUT THIS FORM. THE INFORMATION BELOW IS STATED TO BE TRUE & CORRECT BY SIGNATURE.

Name of patient: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ SS#: \_\_\_\_\_

(Alternate Phone): \_\_\_\_\_

Father's name: \_\_\_\_\_

Father's SS#: \_\_\_\_\_ Father's date of birth: \_\_\_\_\_

Father's employer & phone #: \_\_\_\_\_

Mother's name: \_\_\_\_\_

Mother's SS#: \_\_\_\_\_ Mother's date of birth: \_\_\_\_\_

Mother's employer & phone #: \_\_\_\_\_

Nearest friend/relative not living with you: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Method of payment:                    CASH                    CHECK                    VISA                    MC

Referred by: \_\_\_\_\_

Insurance information: Name of insurance: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Is your illness or injury related to?

Auto Accident: Yes or No Date of accident: \_\_\_\_\_ Claim#: \_\_\_\_\_

Other Accident? Yes or No Accident Date: \_\_\_\_\_ Explain: \_\_\_\_\_

Claim Filing Address; \_\_\_\_\_



## OFFICE FINANCIAL POLICIES

Our office verifies all insurances prior to your first appointment. The information obtained from your insurance carrier is not a guarantee of payment. It is only a review of the patient benefits. Upon our receipt of the insurance company claim payment, our office will address any discrepancies that arise due to incorrect information provided at the time of benefit verification.

### Forms of payment

Our office accepts cash, check (processed through E-check), American Express, Discover, MasterCard or Visa credit cards. If a check is presented for payment of services rendered and it is not honored by the bank due to insufficient funds, the patient will be billed the bank charges and an administrative fee of \$20.00. If you anticipate difficulty paying for the services provided, please speak to the office staff. Alternative payment arrangements can be made in special circumstances.

### Automobile Insurance

Any incident involving an automobile must be filed under the patient's automobile insurance carrier. This includes non-collision accidents such as closing a car door on a finger or sustaining an injury while lifting a load out of a car trunk. Patients that only have automobile insurance will be considered a Self Pay Patient. Our office will file the patient's automobile insurance as a courtesy to the patient. We do not bill third party automobile insurance. Florida is a no fault state, and the patient must file the claim through their own insurance carrier. When/if the automobile insurance pays all claims, the patient will be refunded any credit balance. Patients having additional personal/group insurance will be required to file the automobile insurance as their primary insurance and the personal/group as their secondary insurance. **It is illegal to bill automobile claims to a patient's personal/group insurance until all automobile insurance benefits have been exhausted.**

### Collections

Any accounts being turned over to an outside collection agency will be assessed an administration fee of 10% and a collections fee of 25% of the outstanding balance. The administration fee represents the cost of sending the account to collections, multiple invoicing, lost income, etc. The collections fee is what we will pay the collection agency to collect on the account.



## **Co-Payments**

Co-payments are collected at the time of registration. Patients who are unable to pay their copayment may not be seen.

## **Deductibles**

Patients with large deductibles (over \$250.00) will be required to pay a deposit of \$150.00 at check in. The remaining balance and any lesser deductible amounts will be collected at check out based upon the insurance allowable. Patient credits will be applied to the next visit or refunded if no other appointment is necessary. Refunds are by check and will be mailed to the patient.

## **Insurance Form Completion**

Forms are normally completed within 5-7 business days of receipt. The form completion prepayment is \$25.00 per form, for all forms needing physician completion. The patient must sign a release before the form can be completed.

## **Medical Records**

Patients requesting copies of their medical records must first sign a release form. The charge is \$1.00 per page for the first 25 pages and \$0.50 cents for each additional page thereafter. Records can be picked up with a photo ID; they cannot be mailed. This is to ensure patient confidentiality.

## **Medicare Supplement Insurance**

We are a participating provider with the Medicare Part B program; and as such we are obligated to write off the difference between what Medicare pays us for the services rendered to you (the "allowed amount") and our usual and customary charge. Medicare pays 80% of the "allowed amount" to us directly. The remaining 20% co-pay and your annual deductible of \$135 are the patient's responsibility by federal law.

We do not manually file claims to your Medicare supplement. If Medicare transmits your supplemental information for payment to your insurance company, we will allow 30 days for payment. After 30 days, if payment has not been received by our office, payment of the 20% co-pay to our office and collection from your supplemental insurer will be your responsibility.



### **No-Show**

A \$50.00 no show fee will be applied to the patient's account when the patient has not given our office adequate notice (more than 24 hours) of an office appointment cancellation. Two no show appointments will result in a letter to the patient and primary care physician. Three no show appointments will result in termination of care.

### **Promissory Notes**

Promissory notes are only a courtesy for patients usually seen through the emergency room. Patients are required to set up payment arrangements with the finance manager at the time of check in for their first office visit. Patients should be prepared to make a payment on their first visit. Any patient not in compliance with the terms of their promissory note will be sent to an outside collection agency.

### **Refunds**

Patients will be refunded any overpayment once all claims on the account have been processed and the patient has been discharged from care. The refund may be refunded back to the credit card of the original payment at the patient's request. For all other forms of payment, a refund check will be issued by the accounts payable department in a timely manner. Please note all checks are mailed certified return receipt which requires a signature upon USPS delivery.

### **Self Pay**

All patients without insurance will be required to pay a deposit at check in (\$500.00 for non-fracture care and \$750.00 for patients with a fracture). Any remaining balance for the visit will be collected at check out. Self pay patients paying their bill in entirety at check out are entitled to a 20% discount. This discount does not apply to patients with insurance. Refunds will be paid as per our refund policy (See above).

### **Surgery Cancellation Fee**

Patients, who cancel their surgery with less than 24 hours notice, will be charged a \$200.00 fee for the late cancellation.



### **Surgery Pre-payment**

Patients are required to pay their portion of the surgical fee two (2) business days prior to the surgery. Patients unable to pay may be required to have their surgery rescheduled.

### **Travelers Insurance for International Patients**

Any international patients who have Canadian health care insurance or traveler's insurance, automatically become Self Pay patients. The patient will be responsible for charges at the time of service. It is the patient's responsibility to file their claim with the insurance company. Our office would be happy to assist you with this.

### **Worker's Compensation**

If a patient is injured on the job it must be reported to the employer unless they are worker's compensation exempt. The initial appointment is to be handled through the worker's compensation adjustor. If the employer is worker's compensation exempt, you must provide a copy of the state exemption. Any non-participating worker's compensation carrier will be required to sign our worker's compensation agreement before making any appointments for the patient. The adjustor will be required to provide any non-English speaking patient with a translator.



**Insurance Authorization and Assignment:**

I request that payment of authorized Medicare/other insurance company benefits be made on my behalf to Central Florida Orthopaedic Surgery Associates; P.L. for any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the social security administration, health care financing administration its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (section 1128b of the social security act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**MINOR CHILD CONSENT**

I HEREBY AUTHORIZE THE FOLLOWING PEOPLE TO BRING \_\_\_\_\_ (MY CHILD) TO AN APPOINTMENT IN MY ABSENCE.

\*\*\*ANY CHANGES TO THIS AUTHORIZATION REQUIRE A NOTIFICATION TO OUR OFFICE IN WRITING\*\*\*  
\*\*\*THIS AUTHORIZATION IS VALID UNTIL WRITTEN NOTIFICATION RECEIVED\*\*\*

1 \_\_\_\_\_ (FIRST NAME, LAST NAME)

2 \_\_\_\_\_ (FIRST NAME, LAST NAME)

3 \_\_\_\_\_ (FIRST NAME, LAST NAME)

PARENT NAME: \_\_\_\_\_ (FIRST NAME, LAST NAME)

PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**\*\*IF THIS SECTION IS NOT COMPLETED THE LEGAL GUARDIAN MUST ACCOMPANY THE CHILD TO EACH APPOINTMENT\*\***

**MINOR CHILD CONSENT**

ALL CHILDREN UNDER THE AGE OF 18 MUST BE ACCOMPANIED TO EACH VISIT BY A PARENT/LEGAL GUARDIAN. LEGAL GUARDIAN'S MUST HAVE PROPER COURT DOCUMENTATION INDICATING THEY HAVE BEEN CHOSEN TO BE THE CHILD'S GUARDIAN.

IF THE PARENT/LEGAL GUARDIAN CANNOT ACCOMPANY THE CHILD TO THE APPOINTMENT THEN THE PARENT MUST SIGN A NOTARIZED LETTER GRANTING ANOTHER ADULT (AGE 21 OR OLDER) TO BRING THE CHILD TO THE OFFICE.

PARENT/LEGAL GUARDIAN NAME: \_\_\_\_\_

PARENT/LEGAL GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_