

Joint Replacement Institute

Patient Registration Form

METHOD OF PAYMENT Cash Check Visa/Mastercard/Discover

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____
Address _____ Billing Address? yes no
City _____ State _____ Zip _____ Home Phone _____ Day Phone _____
Alternate Address _____
City _____ State _____ Zip _____ Alternate Phone _____
Birth Date _____ Male Female Single Married **Social Security #** _____
E-mail address _____

CHIEF COMPLAINT TODAY _____
WHO IS YOUR PRIMARY CARE PROVIDER? _____
HOW WERE YOU REFERRED TO US? _____

RESPONSIBLE PARTY

Relationship to Patient _____
Bill to First Name _____ Middle Initial _____ Last Name _____
Billing Address _____
City _____ State _____ Zip _____ Contact Phone _____ Time of Day _____
Social Security # _____ Birth Date _____

INSURANCE INFORMATION

Is Medicare **primary** yes no Medicare **secondary** yes no
Policy # _____ Group# _____
Effective Dates _____ Co Pay? no yes Amount \$ _____
Subscriber Name & DOB _____ Subscriber's Relationship to Patient _____
Insurance Name _____ Phone # _____
Insurance Address _____
City _____ State _____ Zip _____

Please be advised that we are unable to bill any insurance accepted by our office without a copy of the current insurance card. Also, in the event your insurance company denies the claim for ANY reason, you will be personally responsible for the charges incurred.

SURGERY CANCELLATION POLICY

A fee of \$250.00 will be charged if a cancellation for a scheduled surgical procedure is less than 48 hours notice.

Signature

OFFICE VISIT CANCELLATION & NO SHOW POLICY

A fee of \$50.00 will be charged if a cancellation for a scheduled office visit is given less than 24 hours notice from the appointment time.

Signature

ADDITIONAL OFFICE CHARGES

A minimum of \$10.00 fee will be charged on CD's with x-rays or any paperwork packet that requires the providers additional time. \$50.00 additional fee for returned checks.

Signature

ASSIGNMENT OF BENEFITS

I authorize assignment of all medical insurance benefits to the named provider for medical services rendered.

INITIALS

ASSIGNMENT TO PAY FOR SERVICES

I agree to pay Joint Replacement Institute for all charges for services rendered today, or any future date of service, in this office. I understand payment in full **and/or** co-pay **and/or** co-insurance is expected at the time services are rendered. I further understand, in the event this account is referred to an agency or attorney for collection, I will be responsible for all collection fees, attorneys' fees and/or court costs.

INITIALS

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Joint Replacement Institute for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Joint Replacement Institute. I understand that diagnosis or treatment of me by a **Joint Replacement Institute Provider** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Joint Replacement Institute** is not required to agree to the restrictions that I may request. However, if **Joint Replacement Institute** agrees to a restriction that I request, the restriction is binding on **Joint Replacement Institute** and **it's Healthcare Providers**. I have the right to revoke this consent, in writing, at any time, except to the extent that **Joint Replacement Institute** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Joint Replacement Institute's** Notice of Privacy Practices prior to signing this document. The **Joint Replacement Institute's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Joint Replacement Institute**. The Notice of Privacy Practices for **Joint Replacement Institute** is also posted in the Patient Waiting Room. This Notice of Privacy Practices also describes my rights and the **Joint Replacement Institute's** duties with respect to my protected health information.

Joint Replacement Institute reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have read and had the opportunity to have a copy of **Joint Replacement Institute's** Right to Privacy Statement.

Signature of Patient or Personal Representative's Authority

Date