



Northwest Ohio Orthopedics & Sports Medicine, Inc.

Patient Information (Please print in pen)

| | | | | |
|---|-----------------------|---|---|--|
| Legal Last Name: | Legal First Name: | Middle Name: | SSN: | |
| Mailing Address: | City: | State: | Zip: | Email Address: |
| Home Telephone: | Cell Phone: | Other Phone: | Gender: <input type="checkbox"/> M <input type="checkbox"/> F | Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |
| Date of Birth (mm-dd-yyyy): | Date of Injury/Onset: | Work Related: <input type="checkbox"/> Yes <input type="checkbox"/> No | Auto Related: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If Medicare, are you currently residing in a Skilled Nursing Facility: <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Facility _____ | | | | |
| If you are Medicare, have you received Physical, Occupational, or Speech Therapy services since the beginning of the year? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| If so, do you know if you have exceeded the Medicare cap? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| If Medicare, are you currently receiving Home Health Services: <input type="checkbox"/> Yes <input type="checkbox"/> No Type of service: _____ | | | | |
| If yes, Name of Agency: _____ Date of Last Service: _____ | | | | |

Physician Information

| | | |
|---|--------------------|------------------------------------|
| Primary Care Physician (PCP): | City/State of PCP: | Physician who referred you here: |
| May we send medical information to your PCP: <input type="checkbox"/> Yes <input type="checkbox"/> No | | City/State of Referring Physician: |

Employer Information

| | | |
|-----------|-----------------|---|
| Employer: | Employer Phone: | Employment Status: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> None |
| Address: | City: | State: Zip: |

Responsible Party (For Minors and/or Dependents for Insurance Purposes)

| | | |
|--|-------------|-------------------------|
| If Minor, Does child live with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ | | |
| Mother's Legal Name: | Home Phone: | Address (if different): |
| Date of Birth: | SSN: | Employer: |
| Father's Legal Name: | Home Phone: | Address (if different): |
| Date of Birth: | SSN: | Employer: |

Emergency Contact

| | | |
|---------------|--------|---------------|
| Contact Name: | Phone: | Relationship: |
|---------------|--------|---------------|

Health Care Primary Insurance

| | | | |
|--------------------|---|----------|---------|
| Name of Insurance: | Policy or Claim #: | Group #: | Co-pay: |
| Policy Holder: | Date of Birth (mm-dd-yyyy): | SSN: | |
| Employers Name: | Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____ | | |

Secondary Insurance

| | | | |
|--------------------|---|----------|---------|
| Name of Insurance: | Policy or Claim #: | Group #: | Co-pay: |
| Policy Holder: | Date of Birth (mm-dd-yyyy): | SSN: | |
| Employers Name: | Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____ | | |

Authorization: I, with my signature, authorize Northwest Ohio Orthopedics and Sports Medicine, Inc. (NWO) to provide medical care for me, or to this patient for which I am the legal guardian.

I also authorize NWO, to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes, and phone calls concerning care provided or proposed. I shall assign all payment for these services to NWO, realizing I am personally responsible for the charges incurred, including items determined to be non-covered.

I also acknowledge that I have been given or have been offered a copy of the "Practice's" privacy policy as required by law. I request the following restrictions be placed on the "Practice's" use and/or disclosure of my health information (leave blank if NO).

Patient/Guardian: _____ Date: _____



Northwest Ohio Orthopedics & Sports Medicine, Inc.

FINANCIAL POLICY

Regarding Your Insurance:

Our office participates in a variety of insurance plans, and we will submit all claims to those carriers. We make every effort to get claims paid; however, please remember that your insurance policy is a contract between you, your employer, and your insurance company. Any balance remaining after the insurance has paid, is the **patient/guarantor's responsibility** (i.e. co-pay, co-insurance, non-covered benefits, exclusions, etc.). If NWO is not in your insurance plan, the patient/guarantor is responsible for all charges. If you do not have insurance, a payment plan must be arranged, prior to treatment, with our Financial Counselor. Partial payment for self-pay patients is required at the time of the initial visit.

In an effort to minimize insurance errors and maximize insurance payment, please bring your most recent insurance card(s) with you to every visit. **Co-payments are to be paid at the time of your visit.** In the event we receive payment from your insurance company for services you have paid for, a refund will be made to you in a timely manner.

Payment Information:

We accept cash, check, and credit/debit card payments. Credit cards and/or checks can be "kept on file" for your convenience. This information is securely stored by an authorized vendor. Notification will be given before a payment transaction is performed. If you are unable to pay your balance in full, a payment plan arrangement can be made or you can sign up for CareCredit with the option of no interest financing. Contact our Financial Counselor at 419-427-3116 for more information. These options will lessen the possibility of your account being sent to a collection agency because of non-payment. A fee of \$30.00 will be applied and collected from your account if payment is returned non-paid.

Past Due Accounts:

If your balance is not paid in a timely manner, we reserve the right to forward your account to an outside collection agency or attorney. A 10-day notice prior to sending your account to a collection agency will be mailed to you.

Orthopedic No-Show Fee:

Missed or non-cancelled appointments may result in a service fee.

Imaging No-Show Fee:

Cancellation within 24 hours prior to a scheduled MRI or a scheduled CT will be subject to a \$50.00 no-show fee.

Durable Medical Equipment:

If you need to return a product, and you are the original purchaser, you need to do so within 10 days of receiving. All products must be returned in its original packaging with all instructions and parts. The product must be in new condition. We reserve the right to refuse any product not in new condition for health safety reasons. There is a 30% restocking fee on all returns. Upon notification that the product has been returned in new condition, a credit will be issued to your account less the restocking fee. For product exchanges, upon receipt of the returned product we will credit your account minus the 30% restocking fee if a product needs to be exchanged. This charge will be waived if NWO made the mistake in providing you with the wrong product.

FMLA, Disability, and Drug Company Assistance Forms:

Any patient needing forms filled out by our office will incur a one time \$15.00 fee per form. Payment for this service is due at the time of drop-off or pick-up.

Medical Records Copying Fees:

Charges for copying medical records vary depending on whether the individual/organization requesting the information is the patient/personal representative or a non-personal representative. In compliance with the Ohio Revised Code Section 3701.742, if the person requesting records is the patient/personal representative, fees are: \$2.84/page for pages 1-10, \$.59/page for pages 11-50, and \$.24/page for pages 51+. Fees for a non-personal representative are: \$17.48 retrieval fee, \$1.15/page for pages 1-10, \$.59/page for pages 11-50, and \$.24/page for pages 51+. Film prices for patient/representative and non-representative are: \$1.94/sheet or \$1.00/disc. Postage paid to send records will also be paid by the requestor.

Patient/Guarantor Signature

Date