Orthopaedics of Brevard
830 Executive Lane, Suite 120
Rockledge, Florida 32955
(321) 639-2551

****** PLEASE USE BLACK INK ONLY ******

Patient Information

Last Name | First Name | Middle

Date of Birth | Social Security Number | Gender ☐ Male ☐ Female | Martial Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address | City | State | Zip Code

Home Phone Number | Work Phone Number | Other Phone Number (check one) ☐ Cell Phone ☐ Fax ☐ Other | Preferred Method of Contact ☐ Home ☐ Work ☐ Cell

Employment Status: ☐ Full Time ☐ Part Time ☐ Child ☐ Student ☐ Retired ☐ Self-Employed ☐ Not-Employed ☐ Other | Name of Employer | City/State/Zip Code

Race: ☐ American Indian ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Patient Declined

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino ☐ Patient Declined ☐ Unknown

Language: ☐ English ☐ Spanish ☐ Other

Email Address: _____

_____

Next of Kin – Not living with you | Phone | Relationship

Responsible Party Information (if patient is a minor)

Last Name | First Name | Middle | Phone Number

Date of Birth | Social Security Number | Relationship to Patient ☐ Mother ☐ Father ☐ Guardian ☐ Other (explain) _____

Primary Insurance Information

Company Name | Contract/Identification Number

Secondary Insurance Information

Company Name | Contract/Identification Number

Patient Authorization/HIPPA Information

I confirm that all of the above information is true and accurate to the best of my knowledge.

AUTHORIZATION TO TREAT: I hereby authorize any treatment(s), agreed upon which physician may deem advisable.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the provider to release any information acquired in the course of my treatment necessary to process insurance claims.

AUTHORIZATION AND ASSIGNMENT TO PAY BENEFITS TO PHYSICIAN: I hereby authorize and assign all insurance benefits to the provider and authorize payment to be paid directly to the provider for services rendered otherwise payable to me for his/her services. I understand I am financially responsible for deductibles, co-pays, co-insurance amounts and non-covered services.

Signature: _____ Date: _____

By my signature below, I confirm that I have been informed of Orthopaedics of Brevard's "Notice of Privacy Policy" in accordance with the Federal HIPPA act of 1996.

Signature: _____ Date: _____

Referral Information

How did you hear about our office? ☐ Self-Referral ☐ Friend/Family Member ☐ Insurance Company ☐ Newspaper Ad ☐ Phonebook

Physician _____ Other _____

Dear Patient:

Please provide additional information regarding services rendered.

Is the condition being treated related to a pre-existing condition? ____ Yes ____ No

Is the condition being treated the result of an accident/injury? ____ Yes ____ No

Date of accident/injury: _____ State: _____

How did accident/injury occur: _____

Where did accident/injury occur: _____

Is the claim still currently open: ____ Yes ____ No

If no date benefits exhausted/case settled: _____

Have you hired an attorney? ____ Yes ____ No
If Yes Whom _____ Phone # _____

Have you received, or do you expect to receive any payments for your medical expenses from a source other than your health insurance carrier? ____ Yes ____ No

Work injury? ____ Yes ____ No
Did you report this injury to your employer? ____ Yes ____ No

Auto injury? ____ Yes ____ No
In this accident were you the: ___ Driver ___ Passenger ___ Pedestrian___ Other
If you were the driver or passenger were you wearing a seatbelt? ____ Yes ____ No
Where was the point of impact on the vehicle (check all that apply)?
___ Front End ___ Driver Side ___ Passenger Side ___ Rear End ___ Other: _____
Est. amount of damage to vehicle? $ _____ Vehicle Totaled? ____ Yes ____ No
Where was medical treatment obtained? _____ Date: _____

Property injury? ____ Yes ____ No
Name of Property Owner: _____

Student Status: ___ Full-time___ Part-time___ Not applicable

Primary Insurance Carrier: _____
Does another payer cover you other than your health insurance? ____ Yes ____ No
If yes, please list the other insurance carrier _____

I hereby certify the above statements are complete and accurate to the best of my knowledge.

Print Patient Name: _____ DOB: _____

Patient/Parent Signature: _____ Date: _____

FINANCIAL POLICY AND AGREEMENT FOR ORTHOPAEDICS OF BREVARD

We find that communication with our patient helps us in providing the best service to you. We have taken the time to answer some of the most commonly asked questions.

PATIENT IDENTIFICATION: Please note we ask for sensitive information. We understand people are concerned about the exposure of this information and we have policies and procedures in place to protect all your information. In order to be accepted as a patient, you must provide your social security number.

PAYMENT FOR SERVICE IS DUE AT THE TIME THE SERVICE IS RENDERED: We accept cash, personal checks, MasterCard, Visa and Discover Card. Returned checks are subject to the following service charge: $25.00 for returned checks in the amount of $0-$49.00, $30.00 for returned checks $50-$299.00, and $40.00 or 5% of the face amount of the check, whichever is greater for checks over $300.00. In addition, you will lose your privilege to write a check to our office. Past due accounts will be subject to a service charge of 1.5% per month (18.0% APR).

INSURANCE: The doctor's service is provided directly to you and not to an insurance company. We cannot render services on the assumption that charges will be paid for you by the insurance company. As a courtesy to our patients, we submit medical claims to primary, secondary, and tertiary carriers with whom we are contracted. We do not bill to carriers that we are not contracted or third party carriers, this is the responsibility of the patient. You will be expected to pay any co-pay, deductible, co-insurance and non-covered amounts as determined by your policy at the time of service. If your insurance company has failed to pay within a 45-day period, we will expect you to pay the balance of your bill in full. You must then collect from your insurance company. We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. All charges are your responsibility from the date services are rendered.

MEDICARE/MANAGED CARE: Our doctors are participating physicians with the Medicare Program and several managed care plans. As a courtesy to our patients, we will file most secondary insurance for you. If your secondary insurance company has failed to pay within a 30- day period, we will expect you to pay the balance of your bill in full.

MINOR CUSTODY: The parent or individual who completes the paperwork will be the parent or individual responsible for all fees for services rendered regardless of insurance coverage and/or what a divorce decree may state.

FEES: A pre-payment form of $20 will be collected for completing medical forms, disability, employer forms, school forms, etc. We may require 7-10 business days to complete forms. There is a $5 fee for a CD of radiology images.

If it becomes necessary to collect any sum due through an attorney or collection agency, then the patient agrees to pay all reasonable costs of collection, including attorney's fees, whether the suit is filed or not.

Thank you for taking the time to read this policy statement. We hope it answers your questions.

WE ARE HERE TO HELP!

I have read and understand the above financial policy and agree to the terms as stated:

Print Patient Name: _____ DOB: _____

Patient/Parent Signature: _____ Date: _____

AUTHORIZATION FOR DISCLOSURE

DATE_____

I,_____, give authorization for the physicians and staff of
(PRINT NAME)

Orthopaedics of Brevard to:

***A) discuss my medical conditions, health care**
***B) pick up prescriptions, medical procedure orders or x-rays**
***C) payment/insurance information**
***D) ALL of the above**
**********(PLEASE PICK A, B, C, OR D)**

with the following family members or friends:

FULL NAME	RELATION	A, B, C, OR D (see above)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I further understand this authorization will remain in effect unless terminated with a personal dated signature.

Print Patient Name: _____ DOB: _____

Patient/Parent Signature: _____ Date: _____

SIGNATURE OF WITNESS:_____
(Employee of Orthopaedics of Brevard)

ORTHOPAEDICS OF BREVARD

Lawrence G. Robinson, M.D.
General Orthopaedics
Pediatric Orthopaedics
Surgery of the Spine

Brian S. Ziegler, M.D.
General Orthopaedics
Hand & Upper Extremity Surgery

"NO SHOW" AND "LATE CANCELLATION" POLICY FORM

Effective December 11, 2007

Due to the high demand for appointments and the number of "no shows" and "late cancellations", Orthopaedics of Brevard has had to institute a "no show" and "late cancellation" fee.

"No shows" and "Late Cancellations" waste the doctors limited appointment availability and adversely affect the care provided to our patients.

If you are not able to make your appointment, you need to cancel by calling the office at least 48 hours in advance of your scheduled appointment time so that time-slot can be used for another patient. Failing to do so will result in a fee being billed to your account, which will be due upon your next visit. You may cancel appointments by calling our office at 321-639-2551. Voice mail is available during normal business hours so that you can leave a message if a receptionist is unavailable. Please include your name, phone number and date and time of appointment.

All "no shows" and "late cancellations" will be billed as follows:

Office visits and all other regular slot appointments	**$ 20.00**
New patient appointments	**$ 50.00**

This fee is for patients who miss their scheduled appointment or do not cancel within the 48-hour period. These fees are not covered by your insurance and you will be responsible for payment.

Print Patient Name: _____ DOB: _____

Patient/Parent Signature: _____ Date: _____

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Dear Patient:

Our office requires that a valid credit/debit card number and expiration date be on file for which any outstanding balances to be billed or refunds issued.

Your credit card will only be charged the amount identified by your insurance company, not to exceed $500.00 unless approved by you. We will send one (1) statement identifying the balance due, as determined by your insurance carrier.

This policy is no different than using a credit card to reserve a hotel room, rent a car, rent video games, etc. The credit card information provided will be confidential and protected with the same security as your medical record.

As with any other credit/debit card transaction, as a cardholder you have the right to challenge any charges against your account with your Credit Card Company and/or bank.

If you do not have a credit/debit card on file you will be required to pay a deposit for all co-pays, deductibles, co-insurances, and non-covered services prior to your visit.

If you have any questions about this payment policy, please do not hesitate to ask.

Orthopaedics of Brevard

I hereby authorize Orthopaedics of Brevard to charge outstanding patient portion balances for me and/or my dependents to the following credit card:

Please circle one: Visa MasterCard Discover

Account Number: _____ _____ _____ _____ _____

Expiration Date: _____/_____ Signature Code: _____ Billing Zip Code: _____

Name as appears on card: _____

Signature: _____Date: _____

Print Patient Name: _____ DOB: _____

Patient/Parent Signature: _____ Date: _____