Susquehanna Orthopaedic Associates

PATIENT REGISTRATION

___ New Patient __ Established Patient ___ New Injury ____ Work Comp ___ Auto

Patient	Birth Date	Home Phone: Cellphone No. e-mail:

Patient Address	City	State	Zip	Patient's Social Security #

Patient's Employer	Work Phone Number	Occupation
Insurance Name	**Member ID**	**Group #**

Insurance Address and Phone Number

Policy Holder's Name/Person financially responsible for this account	Date of Birth	Social Security #

Policy Holder's Employer	Relationship to insured

Secondary Insurance name	Member ID	Group#	Policy holder's name

Secondary Insurance Address and Phone Number	Relationship to insured	Date of birth of policy holder

Primary Care Physician: (include address and phone)

Person to contact in case of emergency:	Relationship to patient	Phone

Workers' Compensation? Yes No Motor Vehicle? Yes No **If Yes-put W/C or PIP carrier below**	Date of Injury	Treatment authorized by: (CaseManager's Name and Phone No.)

Primary insurance company and Address	Phone Number
Claim Number	Is the insurance through your employer?

I hereby acknowledge the above information is true and correct to the best of my knowledge.

______________________________ Patient, Parent or Guardian Signature (if child is under 18 years old)

______________________________ Date

Susquehanna Orthopaedic Associates

Patient Consent Form

Patient: ____ DOB: ________________________

Please review each paragraph below and sign where indicated

CONSENT TO TREAT

I request consent and authorize the administration and performance of all treatments and diagnostic procedures, including, but not limited to; x-rays, laboratory test, which in the judgment of the providers involved in my care are considered necessary or advisable.

INFORMATION RELEASE

I authorize the release of any medical information necessary to process claims for payment and to those entities to which I may be referred for care, continuity of care or for further testing. Susquehanna Orthopaedic Associates and its employees are hereby released from all liability of any nature that may arise from the release of such information.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment to be made directly to Susquehanna Orthopaedic Associates for surgical and/or medical benefits. In the event that I directly receive any proceeds from my insurance and my account balance is unpaid I agree to pay Susquehanna Orthopaedic Associates within 20 days of the first statement. If my medical insurance or workmen's compensation, insurance plan or auto/liability claim is not verifiable or denied, I agree to pay for all services as presented. If I do not have proper billing information at the time of my visit, I agree to pay for those services at the time of the visit. If surgery is needed, I am aware that my insurance company may require me to pay a 20% coinsurance, and or deductible. I am aware that if payment in full is not received within those 90 days, my account will be sent to collections. I understand that I am personally responsible for and guarantee the payment for all costs of treatment and services rendered. I further agree that if payment in full is not paid when due, I agree to be responsible for and pay a ***finance charge*** of one and one-half percent ***(1.5%)*** per month ***(18% per annum)***, all costs of collection and ***Attorney fees at the agreed rate of 33%*** of the total outstanding balance then due. In the event this matter is filed with the courts, I consent to the personal jurisdiction and venue of the courts of Harford County, Maryland and ***I waive all rights to have this matter tried before a jury.***

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices from Susquehanna Orthopaedic Associates.

By signing below, I acknowledge that I have read and agree with the terms and conditions noted above.

____, SEAL   _________________

Patient's signature, or patient's representative   Date

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of (Name of Practice's) Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of Privacy Practices.

HIPAA

____
Patient Name (Type or Print)

____
Date

____
Signature

John P O'Hearn, MD

Susquehanna Orthopaedic Associates

2 Colgate Dr, Suite 204

Forest Hill, MD 21050

CANCELLATION/MISSED APPOINTMENT POLICY

Your appointment is very important to Dr. O'Hearn and it is reserved especially for you. We understand that sometimes patients are unable to keep a scheduled appointment due to unforeseen circumstances; however we require at least 48 business hours notice for cancellations.

When you forget or cancel your appointment it prevents us from giving you the care you need and it prevents us from filling the appointment time and other patients miss the opportunity to be seen by the doctor.

Our appointments are confirmed in advance because we realize it is easy to forget an appointment you made weeks or months ago. Since the time is reserved for you personally a cancellation fee will apply. This fee is not covered by insurance and will be due to us promptly upon receipt.

Thanks for your understanding.

Signature: ______________________________ Date: __________________________