ORTHOPEDIC SOLUTIONS, LLP a Division of The Centers For Advanced Orthopaedics

*LAUREL: 14201 Laurel Park Drive, Suite 111 * Laurel, MD 20707 * 301-604-3228*
*COLUMBIA: 11055 Little Patuxent Parkway * Suite L-1 * Columbia, MD 21044 * 410-740-7030*

ACCOUNT NUMBER

PATIENT REGISTRATION (Please print & complete entire form)

PATIENT NAME:		*DATE OF BIRTH*	*AGE*	
HOME ADDRESS	*APT #*	*CITY*	*STATE*	*ZIP CODE*
SOCIAL SECURITY #	*MARITAL STATUS* [ ] S [ ] M [ ] D [ ] W	*SEX* [ ] M [ ] F	*EMAIL*	
HAND DOMINANCE Right Left	*RACE AND ETHNICITY*	*PRIMARY PHONE #*	*SECONDARY PHONE #*	
PHARMACY NAME & ADDRESS			*PHARMACY PHONE #*	
EMERGENCY CONTACT PERSON		*RELATIONSHIP*	*PHONE #*	
PRIMARY / REFERRING PHYSICIAN'S (Please provide full names)			*PHONE #*	
EMPLOYERS NAME & ADDRESS		*WORK PHONE #*	*OCCUPATION*	
PT RESIDES AT AN ASSISTED LIVING/NURSING HOME FACILITY: [ ] YES [ ] NO				

REASON FOR TODAY'S VISIT	*ONSET DATE OF INJURY / PAIN*

PRIMARY INSURANCE (Please provide Subscriber's information only)

INSURANCE COMPANY NAME	*ID OR POLICY #*	*GROUP #*	
CLAIMS ADDRESS		*CUSTOMER SERVICE #*	*EFFECTIVE DATE*
SUBSCRIBER'S NAME	*PHONE #*	*SS #*	*DATE OF BIRTH*
SUBSCRIBER'S EMPLOYER	*PHONE #*	*RELATIONSHIP TO PATIENT*	

SECONDARY INSURANCE (Please provide Subscriber's information only)

INSURANCE COMPANY NAME	*ID OR POLICY #*	*GROUP #*	
CLAIMS ADDRESS		*CUSTOMER SERVICE #*	*EFFECTIVE DATE*
SUBSCRIBER'S NAME	*PHONE #*	*SS #*	*DATE OF BIRTH*
SUBSCRIBER'S EMPLOYER	*PHONE #*	*RELATIONSHIP TO PATIENT*	

AUTHORIZATION OF PAYMENT

I, _____hereby authorize **ORTHOPEDIC SOLUTIONS, LLP a Division of CAO** to apply for insurance benefits on my behalf for services rendered to me (or my minor child) and request that all payments made by _____, Insurance Company be sent directly to **ORTHOPEDIC SOLUTIONS, LLP a Divisions of CAO.**

I understand that this in **NO** way relieves me of my responsibility to pay for services, **NOT** covered by my insurance, which was rendered to me (or my minor child). If my account is turned over to a collection agency, a **35%** service fee **will be** added to my past due balance. In addition to the service fee, I will be **fully** responsible for all attorney fees, court costs, and other legal expenses that incur as a result of said collection action. The undersigned agrees that should a suit be filed, venue (location of suit) shall be held in Prince George's, Howard, Montgomery and Anne Arundel Counties and the District of Columbia.

I certify that the information I have reported with regards to my insurance coverage is correct. I authorize the release of **any** information relating to **any** claim for benefits, in order for the claims to be processed. Furthermore, I permit a **copy** of this authorization to be used in place of the original if need be. This authorization **may be** revoked by me at any time in writing.

_____ _____

Signature of Patient, Subscriber or Legal Guardian **Date**

The Centers for Advanced Orthopaedics

Notice of Privacy Practices Acknowledgment Form

Name of Patient (Print): _____

I acknowledge that I have received a copy of the Notice of Privacy Practices (the "Notice") for Centers for Advanced Orthopaedics, LLC.

Signature: _____
(Patient or personal representative with appropriate legal authority)

Date: _____

Electronic Notice: If you would like to receive updates or changes to the Notice electronically, please provide your personal email address:_____. You will also be able to receive paper copies of the current Notice upon request.

If signed by a Personal Representative:

Print Name: _____

Relationship to Patient: _____
(Parent, guardian, etc.)

--- OFFICE USE ONLY ---

If the Patient has a Personal Representative with legal authority to make health care decisions on the Patient's behalf, the Notice must be given to, and acknowledgment obtained from, the Personal Representative. ***If the Patient or Personal Representative did not sign above, document when and how the Notice was given to the Patient or Personal Representative and why the signed acknowledgment could not be obtained.***

Notice of Privacy Practices given to the individual on_____(date) **by:**

Face to face meeting
Mailing
Email
Other: _____

Reason Individual or Personal Representative did not sign this form:

Patient or Personal Representative chose not to sign
Patient or Personal Representative did not respond after more than **one** attempt
Email receipt verification
Other: _____

The Centers for Advanced Orthopaedics

Good Faith Efforts: The following good faith efforts were made to obtain the Patient's signature or , if applicable, the signature of such Patient's Personal Representative. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the Patient's signature or, if applicable, the signature of such Patient's Personal Representative.

Face to face presentation(s): _____

_____

_____

Telephone contact(s): _____

_____

_____

Mailing(s):_____

_____

Email attempts: _____

The Centers For Advanced Orthopaedics
Orthopedic Solutions Division
GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, a patient of Orthopedic Solutions, LLP ("Provider"), understand that my signature below gives the Provider permission, to the extent necessary, to use my medical records, and to provide access to my medical records, while and after I am treated by the Provider for the following reasons:

1. For the purpose of providing treatment to me
2. For the purpose of arranging payment of my care
3. For the purpose of Provider's "health care operations" – This category includes such things as: internal quality assessment activities, contacting other health care providers regarding treatment alternatives, evaluating Provider performance, training providers of care, legal and medical review of care provided, business planning and management, customer service resolutions of internal grievances and the provision of legal and auditing services
4. For the purpose of other health care providers' "health care operations," to the extent that they have a treatment relationship with me

I understand that my permission allows the Provider to transmit permissible information through any means that is reasonably secure, including via email, assuming that reasonable protective measures are taken to preserve the confidentiality of the information.

I understand that I may revoke this authorization at any time, but that the Provider may refuse to give me further treatment if I do so.

I understand that I have the right to know how my medical information is used. If I wish to request a restriction, I will notify the Provider in writing. In this case, the Provider will give me a separate form to fill out, which will also be used for the Provider to indicate whether or not the Provider agrees to the restrictions.

I understand that the Provider may communicate with individuals involved in my care or payment for that care, such as family and friends, unless notified otherwise.

I understand that I have a number of rights identified below:

- The right to review and/or receive a copy of my medical records (a fee may be charged for this service)
- The right to request the amendment (changing) of my medical records
- The right to grant or deny access of my records to others
- The right to decide how information from my records will be conveyed to others
- The right to complain about how my records are handled, to the Secretary of the U.S. Department of Health and Human Services, and to the Provider
- The right to revoke, in writing, any consent that I provide for access to my records
- The right to authorize the Provider to give information about my care to relatives or close friends, to the extent of the involvement with my care or payment
- The right to review a record of access to my medical records

I understand that I have the right to either grant or deny access to my medical records, and that my specific written permission will be sought if access is requested for any reason not set forth above.

The provider may decide to change some of the above-stated policies, and I understand that I will be given a revised Notice if this occurs.

_____ _____

Name of Patient *Signature of Patient or Legally Responsible Individual*

_____
Date

The Centers For Advanced Orthopaedics

Orthopedic Solutions Division

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MEDICAL HISTORY

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

Referring / Primary Physician's Full Name: _____**Referral Name**_____

Hand Dominance: Right Left

Past Medical History:

_____ High Blood Pressure _____ Heart Attack _____ Congestive Heart Failure
_____ Peptic Ulcer Disease _____ Heart Disease _____ Lung Disease
_____ Kidney Disease _____ Liver Disease _____ Diabetes
_____ High Cholesterol _____ Thyroid Disease
_____ Prior Orthopedic Problems _____
_____ Cancer Type: _____
_____ Other: _____

Past Surgical History: _____ No _____ Yes Type: _____

Anesthetic Problems: _____ No _____ Yes Describe: _____

Medications: _____ No _____ Yes If Yes, please list all current medications and dosages: _____

_____

***Allergies to Medications:** _____ No _____ Yes If Yes, please list medications and reaction to medication:_____

_____

Family History: _____ Heart Disease _____ Lung Disease _____ Diabetes _____ Cancer / Type _____

Social History: _____ Alcohol Use _____ Drug Use

***Smoking Status:** _____ Current Every Day (Light / Moderate / Heavy) _____ Current PRN _____ Former _____ Never Smoked

Patient lives alone: _____ No _____ Yes Patient's Occupation: _____Occupation_____

Please check if applicable:

Review of Systems: _____ Fever _____ Chills _____ Weight Loss _____ Weight Gain

Eyes: _____ Glasses _____ Contacts _____ Other: _____
Ears, Nose & Throat: _____ Hearing Loss _____ Hearing Aid _____ Nose Bleeds _____ Dentures
Cardiovascular: _____ Irregular Heartbeat _____ Chest Pain _____ Shortness of Breath
Respiratory: _____ Cough _____ Asthma _____ Environmental Allergies _____ Other_____
Gastrointestinal: _____ Change in Bowels _____ Stomach Burning _____ Hiatal Hernia _____ Diarrhea
_____ Constipation _____ Change in Bladder Control Explain: _____
Skin: _____ Rash _____ Lesions _____ Discoloration
Neurological: _____ Frequent Headaches _____ Blurred Vision _____ Lightheadedness
_____ Numbness or Tingling If Yes, please explain: _____
Psychiatric: _____ Sleep Disturbances _____ Depression _____ Bipolar Disorder _____ Other _____

Reviewed By: _____ **Date:** _____
Medical Staff

The Centers For Advanced Orthopaedics
Orthopedic Solutions Division
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES DISCLOSURE AND ACCESS OF YOUR MEDICAL RECORDS
PLEASE READ CAREFULLY

A. General Authorization for Release of Medical Records authorizes your medical care provider, The Centers For Advanced Orthopaedics, Orthopedic Solutions Division to disclose the information in your medical records to the extent needed for the following:

5. For the purpose of providing treatment to you
6. For the purpose of arranging payment for your care
7. For the purpose of Provider's "health care operations"
8. For the purpose of other health care providers' to the extent that they have a treatment relationship with you

B. Specific Authorization for Release of Medical Records authorizes provider to disclose your medical records to specific people and can contain limitations on their disclosure.

C. You may revoke any authorization provided to Provider by giving Provider a written notice of revocation. Provider may refuse to treat you if you revoke the General Authorization.

D. Provider may be required by law to make disclosures of your record that you have not authorized. Eg: subpoenas in litigation cases, requests by licensure agencies or the U.S. Department of Health and Human Services.

E. Provider may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

F. You have the following rights with respect to your medical records / information:

1. You have the right to request restrictions on the use and disclosure of your medical records / information, however, Provider is not required to agree to restrictions not guaranteed by law. You will be informed if Provider will not agree to a requested restriction.
2. You have the right to receive confidential communications of your health information and to direct the place and manner of communication.
3. You have the right to inspect and receive a copy of your medical records. (Fee may be charged for this service.)
4. You have the right to seek to amend your medical records, and if Provider does not agree with your request, to note your objection in the medical record.
5. You have a right to receive an accounting (list) of disclosures of your medical records / information made by Provider. (Except for those disclosures that fall within the scope of Provider's "health care operations" or disclosures made for payment or treatment purposes).
6. You have the right to receive a paper copy of this notice.

G. Provider is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices. Patients will be provided with revised notices, if changes are made.

H. If a patient believes that his or her privacy rights have been violated, the patient may complain to Provider, or to the Secretary of the U.S. Department of Health and Human Services. To complain to Provider, please write or call us with the details. Provider will not retaliate in any way against a patient for making a complaint.

I. If you as a patient or guardian believe that your privacy rights have been violated, and wish to notify our practice, please call our office and ask to speak with our designated Privacy Complaints Contact Person: Orthopedic Solutions, LLP Practice Manager at 301-604-3228.

The Centers For Advanced Orthopaedics
Orthopedic Solutions Division
DR.'S KUNEC, LAYUG, BULLOCK AND THOMAS

PATIENT AGREEMENT AND AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

- I agree to take full responsibility for the fee for services rendered
- I hereby authorize this office to apply for benefits on my behalf for covered services rendered
- I request payment from my insurance to be made directly to **The Centers For Advanced Orthopaedics** and their Physicians
- I understand that I am responsible for any portion of the charges not covered by my insurance: this includes, but is not limited to the fees not covered in order to meet my deductible, co-insurance, benefits not covered, benefits exhausted or expired, reduced and / or no benefits because patient or responsible party failed to pre-certify treatment with insurance company or failed to supply accurate insurance information for billing
- **I agree to pay all deductibles, co-payments, co-insurances and past balances at the time of service**
- **I agree to pay the full fee at the time of service if I have not obtained the required insurance authorization**
- I authorize the release of medical information to my insurance company in order to determine insurance benefits to which I am entitled
- I authorize a copy of this authorization to be used in place of the original if needed to obtain payment for services rendered
- This authorization may be revoked by me or my insurance company at any time in writing
- **I understand that there is a $30 fee for any paperwork that my Doctor must complete. I am further aware that this fee <u>MUST</u> be paid <u>PRIOR</u> to the completion of these forms. (i.e. FMLA, Short Term Disability, etc.)**
- **I agree to keep all scheduled appointments and to cancel at least 24 hours in advance. I understand that there will be a charge for all missed appointments of <u>$50</u>**

I hereby authorize THE CENTERS FOR ADVANCED ORTHOPAEDICS, ORTHOPEDIC SOLUTIONS DIVISION and the parties listed below to release to each other in writing or by telephone all information and records pertaining to my history, symptoms, diagnosis, testing, functioning, treatments and prognosis. These parties are: **Please specify name on line provided**

_____ Insurance Company __**Primary Insurance Plan //Secondary Insurance Plan**_
_____ Family Doctor: __**Referral Name** _____
_____ Children: _____
_____ Other: _____

Our practice believes that a good doctor/patient relationship is based upon understanding and open communication. Our staff is available to answer any questions you may have about your insurance benefits or to clarify any misunderstandings you may have regarding your balance. Please notify us if a mistake appears on your statement. If you notice that your insurance company has not paid, please contact your insurance company immediately. To facilitate your ability to pay for services rendered, we accept Cash, Check, MasterCard and Visa. **There is a <u>$35</u> charge for all bounced / returned checks personal checks.**

I understand that each month I will receive a monthly statement that is due and payable in full within 30 days from my last visit to the doctor, unless a written payment plan is developed and approved by both parties. I understand that after ninety days, all unpaid accounts will be considered delinquent and will be sent to an attorney for collection and / or court proceeding. I also understand that if my account is delinquent and goes to court that I will be responsible for all of the fees for services: attorney's fees, court costs and interest on my unpaid balance. **I also understand that if collection proceedings begin on my account, I will be unable to be followed within the practice of Orthopedic Solutions, LLP.**

_____*Patient Name*_____
Patient Name

_____ _____Date_____
Patient / Responsible Party Signature ***Date***

The Centers For Advanced Orthopaedics
Orthopedic Solutions Division

DR.'S KUNEC, LAYUG, BULLOCK AND THOMAS

CLAIM FILING WAIVER

PLEASE READ THE ENTIRE DOCUMENT CAREFULLY

I, **_____** am seeking medical treatment from **The Centers For Advanced Orthopaedics, Orthopedic Solutions Division** for an injury / pain which is ***NOT*** related to an automobile, worker's compensation or work related accident or injury.

Prior to services rendered, I was asked by the office staff if the injury / pain was related to auto or work and I informed them it was NOT, therefore services rendered will be submitted to my medical insurance.

I have full knowledge that if my medical insurance denies my claims because they deem it was auto or work related, ***I forfeit*** any and all rights for Orthopedic Solutions, LLP to submit claims to the automobile or worker's compensation insurance company on my behalf and will be ***fully responsible*** for any and all outstanding charges on my account.

If a copy of my medical records is needed to send to the insurance company, Orthopedic Solutions will provide this information once we have a medical release on file.

_____ _____

Patient or Guardian Signature Date

_____ _____

Staff Signature Date

Date of Injury / Onset of pain_____ Body Part _____