

Child Patient Intake

**PATIENT NAME:** \_\_\_\_\_ **SEX:**  M  F  
FIRST NAME MIDDLE INITIAL LAST NAME

**STREET ADDRESS:** \_\_\_\_\_  
**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_ **AGE:** \_\_\_\_\_  
**HOME PHONE:** \_\_\_\_\_ **CELL PHONE:** \_\_\_\_\_ **EMERG CONTACT PHONE:** \_\_\_\_\_  
**EMPLOYER:** \_\_\_\_\_ **WORK PHONE:** \_\_\_\_\_ **SS#:** \_\_\_\_\_  
**EMPLOYER ADDRESS:** \_\_\_\_\_  
**IF FULL TIME STUDENT INDICATE SCHOOL CURRENTLY ATTENDING:** \_\_\_\_\_  
**EMAIL:** \_\_\_\_\_

**Parent/Legal Guardian information: (Any patient under the age of 18 years old must have a parent or legal guardian present at each visit.) The information below must be completed by the individual accompanying the patient today.**

**RESPONSIBLE PARTY:** : \_\_\_\_\_ **SEX:**  M  F  
FIRST NAME MIDDLE INITIAL LAST NAME

**DATE OF BIRTH** \_\_\_\_\_ **SS#:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_  
**DATE OF BIRTH** \_\_\_\_\_ **HOME PHONE:** \_\_\_\_\_ **CELL PHONE:** \_\_\_\_\_

**REFERRAL SOURCE:** ( ) Primary Care Physician ( ) Specialist Physician: \_\_\_\_\_ ( ) Friend  
 ( ) ER: \_\_\_\_\_ ( ) Family Member ( ) Insurance Company ( ) Other: \_\_\_\_\_  
**PRIMARY CARE PHYSICIAN:** \_\_\_\_\_ **PHONE#:** \_\_\_\_\_  
**PRIMARY CARE PHYSICIAN ADDRESS:** \_\_\_\_\_

**PRIMARY INSURANCE:** \_\_\_\_\_  
**POLICY:** \_\_\_\_\_ **GROUP:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_  
**RELATIONSHIP TO INSURED:** \_\_\_\_\_ **POLICY HOLDER NAME :** \_\_\_\_\_  
**POLICY HOLDER SS#:** \_\_\_\_\_ **POLICY HOLDER DATE OF BIRTH:** \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_  
**POLICY:** \_\_\_\_\_ **GROUP:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_  
**RELATIONSHIP TO INSURED:** \_\_\_\_\_ **POLICY HOLDER NAME :** \_\_\_\_\_  
**POLICY HOLDER SS#:** \_\_\_\_\_ **POLICY HOLDER DATE OF BIRTH:** \_\_\_\_\_

**NO FAULT INFORMATION – FILL THIS OUT IF YOU WERE INJURED IN A CAR ACCIDENT:**

**INSURANCE COMPANY:** \_\_\_\_\_  
 (VEHICLE YOU WERE IN AT TIME OF ACCIDENT)  
**INSURANCE COMPANY ADDRESS:** \_\_\_\_\_ **PHONE#:** \_\_\_\_\_  
 \_\_\_\_\_ **FILE#:** \_\_\_\_\_  
CITY STATE ZIP  
**DATE OF ACCIDENT:** \_\_\_\_\_ **POLICY OR CLAIM#:** \_\_\_\_\_  
**NAME OF INSURED (IF OTHER THAN CLAIMANT):** \_\_\_\_\_  
**ADDRESS OF INSURED:** \_\_\_\_\_ **DATE LAST WORKED:** \_\_\_\_\_  
 \_\_\_\_\_ **LOCATION OF ACCIDENT:** \_\_\_\_\_  
CITY STATE ZIP  
**HISTORY OF ACCIDENT:** \_\_\_\_\_

**WORKER'S COMPENSATION INFORMATION ONLY:**

**WORKER'S COMPENSATION INSURANCE CARRIER:** \_\_\_\_\_  
**ADDRESS OF CARRIER:** \_\_\_\_\_ **PHONE#:** \_\_\_\_\_  
 \_\_\_\_\_ **CITY STATE ZIP**  
**DATE OF INJURY:** \_\_\_\_\_ **LOCATION:** \_\_\_\_\_  
**WCB CASE#:** \_\_\_\_\_ **POLCY OR CLAIM#:** \_\_\_\_\_  
**HOW WERE YOU INJURED?:** \_\_\_\_\_  
**DATE LAST WORKED?:** \_\_\_\_\_

## Patient Financial Policy

**Co-pays:**

The patient is expected to present a valid insurance card at each visit. All co-payments and past due balances are due and payable at the time of service.

**Self-pay accounts:**

Self-pay accounts are:

- Patients who are covered by insurance plans that the practice does not participate in.
- Patients without insurance information of file.
- Patients without an insurance card at the time of service, do not meet the deductible,
- Payment is required at the time of service for all services.

**Extended Payment Arrangements:**

For procedures exceeding \$300.00: 75% of the total fee is to be paid at the time of service. The remaining balance is to be paid over the next three months in equal monthly payments due by the first of every month. OADC reserves the right to add a service charge or interest to any extended payments. Patients who fail to make a monthly payment will be sent to a collection agency and may be terminated from the practice. Alternative payment schedules must be arranged with the billing department prior to surgery.

**Non-participating Insurance Plans:**

The financial obligations of patients who are insured by carriers that the practice does not participate with are considered a self-pay account. The insurance company will be billed as a non-assigned claim as a courtesy to the patient with the patient paying the practice the amount in full. The insurance company will reimburse the patient on non-assigned claims. \*For surgical procedures please ask to speak to a billing representative prior to the procedure. If the practice receives payment for a non-assigned claim, the patient will receive a refund.

**Patient Refunds:**

The following criteria must be met prior to Orthopedic Associates issuing a patient refund: The patient has not been treated by the practice for 90 days, there are no outstanding insurance claims on the patients account, and there are no outstanding patient balances on the account.

**Divorce Cases:**

In the case of divorce, the individual who receives the care is responsible for payment of co-pays, coinsurance, and non-participating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.

**Child Custody Cases:**

The parent with primary custody is usually the parent whom the child lives and usually brings the child to the practice for care. The custodial parent is responsible for payment at the time of service whether the account is considered self-pay, participating insurance, or non-participating insurance. If the non-custodial parent carries the insurance on the child, the office will bill that insurance company. The practice does not get involved with divorce specifics, e.g., one parent pays 80% and the other pays 20%. It is the parents obligation to work out an agreement themselves or through the court system.

**Referrals:**

If your insurance has designated a primary care physician (PCP), you are required to have prior authorization from your PCP prior to your office visit. If authorization is not provided, you will be asked to either reschedule your appointment or pay for the visit at the time of service.

This financial policy helps the practice provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

**AUTHORIZATION FOR PAYMENT**

I authorize the release of any medical information necessary to process insurance claims (including HIV/AIDS, Drug and Alcohol abuse, and mental illness) and the release of information back to my physician. I also authorize payment of medical benefits to ORTHOPEDIC ASSOCIATES OF DUTCHESS COUNTY, P.C. for services rendered. In the event that my medical insurance does not pay for services rendered, I agree to pay Orthopedic Associates of Dutchess County, P.C. for these services.

**The patient or legal guardian is responsible for payment of services.**

*****Signed _____	Date _____	*****
Signature of Patient/Legal Guardian if patient is a minor		

**\*\*\*\*\*MEDICARE BILLING WAIVER\*\*\*\*\***

I request that payment of authorized MEDICARE benefits be made to me or on my behalf to ORTHOPEDIC ASSOCIATES OF DUTCHESS COUNTY (Drs. William Kwock, Ronald Scheinzeit, Gary Fink, David Dimarco, David Stamer, William Barrick, Russell Tigges, Lawrence Kusior, Sasha Ristic, Michael Schweppe, Wen Shen, Richard Perkins, Carl Barbera, William Colman, Andrew Stewart, Stephen Maurer, Samant Virk, Niraj Sharma, Maryanne Wysesell; Stephen Lebitsch, NP; Physician Assistants Warren Sheprow, Judith Schachte, Kathleen Hefferon, Kristin Miller, Sijo Padannamackal, Heidi Lim and Dawn Oretsky; Physical Therapists Robin Mostachetti, Charles Hargreaves, Matthew Wagner, Keith Claire, Rocco Occhiogrosso, Heather Fassell and Tamara Claire; Occupational Therapists Marc Bartholdi, Christina McGrath, Carol Dollard, Heather Kelly, Lorraine Gogreve and Deana Forlenza) for any services furnished to me by those physicians/providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent to any information needed to determine these benefits or the benefits payable for related services.

*****Signed _____	Date _____	*****
Signature of Patient		



**ACKNOWLEDGEMENT OF RECEIPT  
OF  
NOTICE OF PRIVACY PRACTICES  
AND  
NO SHOW/CANCELLATION POLICY**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and the Practice No Show/Cancellation Policy and that I have read (or had the opportunity to read if I so chose) and understood the Notices.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
Signature