Orthopedic Associates of Dutchess County
www.orthoadc.com

OrthoExpress WALK-IN CENTER

Today's Date ___/___/_____

PATIENT INFORMATION	
Name:	**Date of Birth:**
Address One:	**Social Security #:**
Address Two:	**Sex:**
City:	**Patient Age:**
State: **Zip:**	**Employer:**
Home Phone#:	**Email Address:**
Work Phone#:	**Emergency Contact:**
Cell Phone#:	**Emergency Phone#:**
PCP:	**Emergency Contact DOB:**
GUARANTOR INFORMATION	
Name:	**Date of Birth:**
Address One:	**Social Security#:**
Address Two:	**Home Phone#:**
City:	**Work Phone#:**
State: **Zip:**	**Cell Phone#:**
INSURANCE INFORMATION	
Primary Insurance:	**Secondary Insurance:**
ID#:	**ID#:**
Group #:	**Group #:**
Copay:	**Copay:**
Subscriber Name:	**Subscriber Name:**
Work related injury? Y N **Auto Accident? Y N** *** If you have answered yes please provide the workers compensation insurance or No Fault (auto) insurance in addition to your private medical insurance **** ****Attention**** **Please Read And Sign:**	

I agree that Orthopedic Associates of Dutchess County, P.C. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. ____ ____Initials _____ Date

Pharmacy Name:_____City/Town:_____Ph#_____

Your patient information may be used to contact you by telephone/mail for the purpose of treatment, payment or health care operations. If you have any restrictions for communication with you please let us know on this line. _____

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices Policy. I have read (or have the opportunity to read if I choose) and understand the notices.

Patient Name (Please Print) Date_____

_____

Parent or Authorized Representative (if applicable)

_____

Signature

Patient Financial Policy

Co-pays, Coinsurances, Deductibles and Finance fees:

The patient is expected to present a valid insurance card at each visit. All payments and past due balances are due and payable at the time of service. Auto pay is available via credit card to resolve balances.

- Deductible policy: If you have not met your deductible for the calendar year OADC requires a down payment toward your estimated cost of your visit. New consultations require $250 and all follow up exams require $100 at check in. Once your insurance has processed your claim the balance due will be sent to you for payment.

- **Finance charge: Any copay not paid at time of service will be charged a $25 finance fee.**

Self-pay accounts:

Self-pay accounts are:

- Patients without valid insurance coverage at time of service.

- Expected to pay for all services at the time of service. Auto pay is available via credit card to resolve balances.

Extended Payment Arrangements: All payment agreements must be made in writing.

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.

The policy for balances:

- **Balances up to $500.00:** Patient may make a monthly payment plan. The total balance must be resolved within 90 days. Auto pay is required.
- **Balances in excess of $1,000.00:** Patient may make a monthly payment plan. The total balance must be resolved within 180 days. Auto pay is required.
- **Balance in excess of $5,000.00:** A payment of $500.00 is due at the time of service. The total balance must be resolved within one year of the date of service. Auto pay is required.

Durable Medical Equipment (DME):

All durable medical equipment is to be paid in full at the time of service.

Non-participating Insurance Plans:

The financial obligations of patients who are insured by carriers that the practice does not participate with are the patients' responsibility. 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.

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 as per the terms of your 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.

AUTHORIZATION FOR RELEASE OF INFORMATION AND PAYMENT

I authorize the release of any medical information requested by my insurance carrier (including HIV/AIDS, drug and alcohol abuse, and mental illness) for administration of claims and services, 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 parent or legal guardian is responsible for payment of 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. Gary Fink, David Dimarco, William Barrick, Russell Tigges, Lawrence Kusior, Sasha Ristic, Michael Schweppe, Wen Shen, Richard Perkins, Carl Barbera, William Colman, Andrew Stewart, Stephen Maurer, Mark Aierstok, Frank Lombardo, John McLaughlin, Kenneth Rauschenbach, Nicholas Renaldo, Donna Flynn, Richard Dentico, Brian Reade, Vishal Rekhala; Stephen Lebitsch, NP, Jennilyn Whittam, NP, Jean Walsh, NP, John Mazzei; Physician Assistants Warren Sheprow, Kathleen Hefferon, Theresa Skelly, Jonathan Rawls, Kimberly Farrugia, and Sijo Padannamackal, Bridget Beebe, Joanna Whitback; Physical Therapists Keith Claire, Charles Hargreaves, Christine Poole, Anna Chetnik, Meredith Auerbach, Michael Oser, Matthew Podhaiski, Dean Havner, Laurie Barnum and Occupational Therapists Christina McGrath, Carol Dollard, Heather Kelly, Amram Lavi-Romer, Jennifer Yozzo, Karin Lipke, Jennifer Orphal and Jessica Simpson) 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**_____***********

PRESCRIPTION MEDICATION POLICY

Due to the increasing rate of narcotic dependence/abuse nationwide, we at Orthopedic Associates of Dutchess County have developed a Prescription Medication Policy limiting the use of prescription drugs in accordance with DEA and FDA guidelines. Please read this document carefully as this policy will be strictly enforced.

In general, narcotic pain medications will ONLY be prescribed for post-operative pain or after an acute injury. Patients who receive narcotic prescriptions will be closely monitored. Narcotics will generally be prescribed for a period of two to three weeks after a surgical procedure unless your surgeon extends the prescribing period based on your surgical procedure. There are, of course, occasional exceptions to the rule at the discretion of your treating physician. If you feel that you require narcotic pain medication after this point, we will provide you with the names of Pain Management providers who specialize in the treatment of chronic pain.

You must take the medication only as directed on the bottle, as refills will not be provided unless deemed necessary by your treating physician. If a patient is found to be taking these medications more than directed, or in the event of suspected narcotic abuse, further prescriptions of narcotic pain medications will not be provided.

The use of narcotics may affect your alertness, reaction time, judgment, and/or decision-making abilities. You should not drive, operate machinery, or make important decisions while under the influence of narcotics. Narcotics carry a risk of overdose. Do not combine narcotic use with the use of illegal drugs, alcohol, or controlled substances.

In the event that you are prescribed a narcotic that is ineffective in managing your pain or causes an adverse reaction, you must properly dispose of the remaining medication at a designated medication drop box prior to receiving a prescription for an alternate medication. A list of drop boxes, many of which are at police stations, is available upon request. We recommend obtaining a receipt for the medication disposal, if available.

Prescription refills may take up to three (3) business days to process, so you must call in advance. We may need to see you to reevaluate your condition prior to renewing your prescription. Narcotic refills will NOT be provided after regular business hours.

To request a refill prescription, please contact your physician's patient care coordinator. When leaving a message, please indicate your name, date of birth, phone number, drug allergies, the name and phone number of your pharmacy, and the name and dosage (strength) of the medication. New York State law requires that all prescriptions must be sent to your pharmacy electronically, so it is vital that you provide us with the correct information.

Lost, damaged, or stolen prescriptions will NOT be replaced.

If you are receiving narcotics from another physician, you are expected to disclose this information to us at the time of your first visit. If this office receives notification that a patient is receiving narcotics from more than one physician, prescribing of such medication by this office will be immediately suspended. New York State has a central database that tracks prescriptions for controlled substances. Our office will consult this database prior to issuing a prescription.

If you feel that your symptoms are an emergency, you should seek medical attention at the nearest emergency room.

We have created this policy to ensure the health and safety of our patients. We appreciate your cooperation. By reading and signing this policy, you agree to the terms listed above. If you do not agree, we would be happy to assist you in finding a provider better able to meet your needs.

Patient Name:_____ Date: _____

Patient Signature: _____ MRN#:

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Cancellation and No-Show Policy

Cancellation/No Show Policy for Physician and Therapy appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

In order to provide the best care for our patients, if an appointment is not cancelled within 24 hours in advance, you will be charged a twenty-five dollar ($25.00) fee. We reserve the right to charge a no show fee. This fee is not covered by insurance. You will receive a bill in the mail.

Orthopedic Associates of Dutchess County firmly believes that good physician/ patient relationships is based upon good communication.

Cancellation/No Show Policy for MRI and Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the surgery center. Please understand that when you schedule surgery, an entire team of people and an operating room has been reserved for your care. When surgery is cancelled without advance notice, we cannot recoup our expenses. We do a lot of preparation and calls to ensure that everything goes smoothly on the day of your procedure.

If surgery is not cancelled at least three (3) days in advance, you will be charged two hundred and fifty dollars ($250.00). We reserve the right to charge a no show fee. This fee is not covered by insurance. You will receive a bill in the mail.

If your MRI scan is not cancelled at least two (2) days in advance, you will be charged two hundred and fifty dollars ($250.00). We reserve the right to charge a no show fee. This fee is not covered by insurance. You will receive a bill in the mail.

We appreciate your understanding of the above stated policy and thank you for your cooperation. Please feel free to call us with your questions and concern at **845.454.0120**.

Patient Name:_____ Date: _____

Patient Signature: _____ MRN#: