

Winchester Orthopaedic Associates, Ltd.

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 Fax: 540/667-6589

1830 Amherst Street, Winchester, VA 22601
 Ph: 540/536-4787
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PATIENT AUTHORIZATION

Please Print Clearly

PATIENT NAME		LAST	FIRST	MIDDLE	SUFFIX (SR, JR, III, ETC)	
SEX	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH		SOCIAL SECURITY NO.		
RACE	<input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> INDIAN	<input type="checkbox"/> ASIAN	<input type="checkbox"/> BLACK OR AFRICAN AMERICAN	<input type="checkbox"/> CAUCASIAN	<input type="checkbox"/> GREEK	<input type="checkbox"/> HISPANIC <input type="checkbox"/> SPANISH AMERICAN <input type="checkbox"/> PREFER NOT TO ANSWER
ETHNICITY		<input type="checkbox"/> NOT HISPANIC OR LATINO		<input type="checkbox"/> HISPANIC OR LATINO		<input type="checkbox"/> PREFER NOT TO ANSWER
HOME ADDRESS		APT. NO.	CITY	STATE	ZIP CODE	
MAILING ADDRESS		APT. NO.	CITY	STATE	ZIP CODE	
HOME PHONE	CELL PHONE	FAX	EMAIL			
PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS						
<input type="checkbox"/> HOME PHONE		<input type="checkbox"/> WORK PHONE		<input type="checkbox"/> CELL PHONE		<input type="checkbox"/> EMAIL
EMPLOYER	OCCUPATION		WORK PHONE	EXT.	FAX	
EMPLOYER ADDRESS			CITY	STATE	ZIP CODE	
SPOUSE (OR PARENT) NAME				SPOUSE (OR PARENT) SOCIAL SECURITY NO.		
SPOUSE (OR PARENT) ADDRESS			CITY	STATE	ZIP CODE	
SPOUSE (OR PARENT) EMPLOYER				SPOUSE (OR PARENT) WORK PHONE		
IN CASE OF EMERGENCY NOTIFY				HOME PHONE		WORK PHONE

BILLING AND INSURANCE INFORMATION

	LAST NAME	FIRST NAME	MIDDLE	RELATIONSHIP TO PATIENT
SEND BILL TO	MAILING ADDRESS		CITY	STATE
	EMPLOYER		WORK PHONE	HOME PHONE
PRIMARY INSURANCE	INSURANCE COMPANY NAME		ID OR POLICY NUMBER	GROUP / CODE
	INSURANCE COMPANY ADDRESS		PHONE #	SUBSCRIBER'S SOCIAL SECURITY
	SUBSCRIBER'S NAME		SEX	HOME PHONE
	SUBSCRIBER'S ADDRESS		WORK PHONE	SUBSCRIBER'S DATE OF BIRTH
SECONDARY INSURANCE	INSURANCE COMPANY NAME		ID OR POLICY NUMBER	GROUP / CODE
	INSURANCE COMPANY ADDRESS		PHONE #	SUBSCRIBER'S SOCIAL SECURITY
	SUBSCRIBER'S NAME		SEX	HOME PHONE
	SUBSCRIBER'S ADDRESS		WORK PHONE	SUBSCRIBER'S DATE OF BIRTH

FOR MEDICARE PATIENTS ONLY:

ARE YOU CURRENTLY IN A SKILLED NURSING FACILITY? NO YES FACILITY NAME: _____

You are authorizing care and treatment by the Providers of Winchester Orthopaedic Associates:

Patients or their representatives have the right to fully participate in decisions about their care and treatment, and should expect to be given the information necessary in order to make reasonably informed decisions about treatment options, surgery, or invasive procedures. Patients or their personal representatives are encouraged to ask questions about all aspects of their orthopaedic care. Favorable results or outcomes depend on patient participation and compliance with the mutually agreed upon plan of care.

I authorize Winchester Orthopaedic Associates, Ltd., to release any information, including information concerning drug or alcohol abuse, psychiatric care and HIV, acquired in the course of my examination or treatment to my insurance carrier, to my employer in the event of a work related injury, or to any other person or agency deemed appropriate by my physician.

I authorize any physician, hospital, or medical care facility to provide all my medical history and treatment to Winchester Orthopaedic Associates.

I authorize Winchester Orthopaedic Associates, Ltd., to test my blood for hepatitis and for the AIDS virus, if in their opinion, an employee of Winchester Orthopaedic Associates, Ltd., has suffered an exposure incident as a result of my treatment defined by the Occupational Safety and Health Administration.

A law was enacted in 1989 and amended in 1993 which authorizes health care providers to test their patients for HIV, Hepatitis B and C antibodies when the health care provider is exposed to the body fluid of a patient in a manner which may transmit these antibodies. Pursuant to this law, in the event of such exposure, you will be deemed to have consented to such testing and to the release of the test results to the health care provider who may have been exposed. You will be informed prior to your blood being tested for HIV, Hepatitis B or C antibodies. The testing will be explained, and you will be given the opportunity to ask any questions.

Your financial obligation to the providers of Winchester Orthopaedic Associates is as follows:

I request that payment of authorized Medicare benefits made either to me or on my behalf to Winchester Orthopaedic Associates, Ltd., for any services furnished to me by the physician or supplier. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, or my insurance company and information needed to determine these benefits payable for related services.

I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any necessary information including medical information for this or any related claim, to the above named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Winchester Orthopaedic Associates, Ltd., for any services furnished me by the physician or supplier. I authorize any holder of medical information about me to release information needed to determine these benefits payable for related service.

I authorize Winchester Orthopaedic Associates, Ltd., to file a complaint on my behalf with the State Corporation Commission Bureau of Insurance.

Date

Patient/Guardian

Verbal Authorization Acquired

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Patients who carry health insurance should remember that professional service fees are charged to the patient and not to the insurance company. Your insurance company has no obligation to pay for our services; its obligation is to you, the policy holder. You will receive a statement each month when your account has a balance due. You are responsible for payment of your account within 30 days of receipt of your statement. Although this office cannot accept responsibility for checking insurance payments or negotiating a settlement on a disputed claim, we will try to assist you with any problems concerning your insurance. In the event of non-payment of your account, you understand that you will be responsible for the balance. If your account is referred to a collection agency you will be responsible for the balance plus an additional collection charge of 33%.

Date

Patient/Guardian

PRESCRIPTION MONITORING PROGRAM (PMP)

Effective 10/02/2009, Winchester Orthopaedic Associates participates in the Prescription Monitoring Program (PMP) regulated by the Virginia Department of Health Professions and the Controlled Substance Monitoring Program regulated by the West Virginia Board of Pharmacy. These programs collect data on controlled prescription drugs dispensed in Virginia and West Virginia to promote appropriate use of controlled substances.

Release of Your Personal Health Information (HIPAA/Privacy Authorization):

I authorize Winchester Orthopaedic Associates and any physician or other medical service provider who renders service to me to release to the physician treating me, insurance company, reimbursing agency, Valley Health affiliated entities, attorneys and others as allowed by the law whatever information, including a copy of, or electronic access to, my medical record for determination of benefits payable or for additional medical care information.

I give this office authorization to contact me **directly** at work or leave messages on my answering machine at home regarding my care.

Yes No Signature: _____

Please list any persons you would like to authorize to have access to your billing, appointment or health information such as your spouse, caregiver or family member: Provide SS#/DOB/Maiden Name of the individual so we may identify the individual over the phone.

Name	Relationship	Contact Number	SS#/DOB/Maiden Name
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date

Patient/Guardian