COUNTRYSIDE
ORTHOPAEDICS • PHYSICAL & HAND THERAPY

PATIENT REGISTRATION

PATIENT INFORMATION

TODAY'S DATE_____ PATIENT'S SSN _____ GENDER ☐ Male ☐ Female

PATIENT'S NAME _____ PATIENT'S DOB _____ AGE _____

ADDRESS_____ APT # _____ CITY_____ STATE_____ ZIP_____

PHONE (H)_____ PHONE (W) _____ PHONE (C)_____

PREFERRED PHONE ☐ Home ☐ Work ☐ Cell *MAY WE LEAVE A VOICEMAIL REGARDING YOUR APPOINTMENTS AND/OR TREATMENT?* ☐ YES ☐ NO

WOULD YOU LIKE TO RECEIVE EMAIL UPDATES? ☐ YES ☐ NO EMAIL_____

EMERGENCY CONTACT NAME_____ PHONE_____

EMERGENCY CONTACT RELATIONSHIP TO PATIENT ☐ Parent ☐ Spouse ☐ Other_____

In compliance with the American Recovery and Reinvestment Act of 2009 (AARA) to demonstrate Meaningful Use, we are required to capture demographic data including your race, ethnicity and preferred language.

RACE
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian
- ☐ White
- ☐ Patient declined information

ETHNICITY
- ☐ Hispanic Origin
- ☐ Non Hispanic Origin
- ☐ Unknown
- ☐ Patient declined information

PREFERRED LANGUAGE
- ☐ English
- ☐ Spanish
- ☐ Other_____
- ☐ Patient declined information

MARITAL STATUS
- ☐ Divorced
- ☐ Married
- ☐ Separated
- ☐ Single
- ☐ Widow

EDUCATION
- ☐ High School
- ☐ College
- ☐ Graduate School
- ☐ Other_____

STUDENT
- ☐ Full-time student
- ☐ Part-time student
- ☐ None/Not a student

EMPLOYMENT
- ☐ Full-time employed
- ☐ Part-time employed
- ☐ Retired
- ☐ Self-employed
- ☐ Unemployed

OCCUPATION_____

EMPLOYER NAME :_____

PCP or FAMILY PHYSICIAN _____ PHONE_____ FAX_____

REFERRING PHYSICIAN_____ PHONE_____ FAX_____

PHARMACY NAME, ADDRESS & PHONE_____

FINANCIALLY RESPONSIBLE PERSON

Complete this section if the patient is a minor OR if the financially responsible party is not the patient

NAME _____ SOCIAL SECURITY #_____

DATE OF BIRTH_____ GENDER ☐ Male ☐ Female RELATIONSHIP TO PATIENT_____

ADDRESS_____ APT # _____ CITY_____ STATE_____ ZIP_____

PHONE (H)_____ PHONE (W) _____ PHONE (C)_____ EMAIL_____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY_____ PHONE_____

POLICY HOLDER NAME _____ POLICY HOLDER SSN # _____

POLICY HOLDER DATE OF BIRTH_____ POLICY HOLDER'S EMPLOYER _____

PATIENT'S RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Natural Child ☐ Other Relationship Not Listed

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY _____ PHONE _____

POLICY HOLDER NAME _____ POLICY HOLDER SOCIAL SECURITY # _____

POLICY HOLDER DATE OF BIRTH _____ POLICY HOLDER'S EMPLOYER _____

PATIENT'S RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Natural Child ☐ Other Relationship Not Listed

By supplying my insurance information, I hereby authorize COUNTRYSIDE ORTHOPAEDICS, PC (CSO) to file on my behalf for payment of any medical benefits arising out of any insurance covering me and/or my dependents and hereby assign benefits to CSO for application on the patient's bill. I certify that the information reported in regard to my insurance coverage is accurate and complete and further authorize the release and re-disclosure of any necessary information, medical or other, required to facilitate any claim to determine benefits to which I may be entitled and to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party, health maintenance organization, insurer or other health benefit plan. This consent applies to CSO or any of its affiliates or agents, lenders, or third party servicer(s) acting for CSO or any of its affiliates.

SIGNATURE: _____

FOR MEDICARE PATIENTS ONLY

If you are enrolled in Medicare and are under the age of 65 is your status working disabled? ☐ No ☐ Yes, *please explain* _____

Do you currently reside in a Skilled Nursing Facility? ☐ Yes ☐ No If Yes, SNF NAME _____

Are you currently receiving Home Health services (physical and/or occupational therapy in your own home)? ☐ Yes ☐ No

If Yes, list start and end date(s) service received _____

Have you had any of the following services, chiropractic, physical and/or occupational therapy, at another facility or doctor's office this calendar year?

☐ Yes ☐ No If Yes, please indicate services received: ☐ Chiropractic ☐ Physical Therapy ☐ Occupational Therapy

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (HIPAA) & PERMISSION TO DISCLOSE

I authorize the following person(s) access, inquire, or obtain on my behalf, my protected health information (PHI) as necessary during the course of your healthcare services and treatment.

NAME & RELATION	PHONE CONTACT	DATE OF BIRTH

I acknowledge receipt of the Notice of Privacy Practices and Permission of Disclosure of Countryside Orthopaedics, PC.

Patient/ Guardian Name _____ Patient/Guardian Signature _____ Date _____

NOTICE OF DISCLOSURE OF OWNERSHIP INTEREST

Our physicians have a financial relationship in the form of ownership or investment interest in the following ambulatory surgery centers (ASC):

INOVA Loudoun Ambulatory Surgery Center	Raymond F Lower, DO / Imran A Khan, MD / Adam Lorenzitti, MD
Point of Rocks Ambulatory Surgery Center	Raymond F Lower, DO / Imran A Khan, MD

The federal laws which govern Medicare, Medicaid and other federally-funded programs and the public law of the State of Virginia require that physicians who have an investment in an ambulatory surgery center inform their patients of that investment. These physicians have become owners as a result of their commitments to quality healthcare and service to their patients.

You have the right to choose where to receive services, including an entity in which your physician has a financial relationship. You may, of course, seek treatment at another ambulatory surgery center provider in which your physician does not have an investment. Our office can assist you in selecting an alternative facility and scheduling your appointment. Your choice of facilities may be limited by your health plan and you may wish to consult your health insurer prior to making a selection. If you wish to have your surgery performed at a facility other than those listed above, be assured that your choice of facility will in no way diminish the level of care you will receive from this medical practice.

By my signature below, I am acknowledging this Notice of Disclosure and Ownership Interest on the date set forth below.

Name of Patient _____ Signature of Patient _____ Date _____

COUNTRYSIDE
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FINANCIAL POLICY

1. Please update your address, telephone numbers, current insurance card(s) and photo id when you check-in for your appointment. Insurance carriers mandate that we update this information each calendar year. Patients who do not arrive for their appointment with their current insurance card, photo id, and/or copay may be rescheduled. Self-pay patients who do not arrive with a method of payment for services rendered at the initial visit will be rescheduled.

2. It is the patient's responsibility to know if their insurance requires a referral to see a specialist, which must be presented at your initial appointment. Our contracts with these insurance carriers mandate that we cannot see their patients without a *Referral or Consultant Treatment Plan*. Please check with the receptionist at check out to ensure that your referral will still be valid for your next appointment.

3. Payment is due at the time services are rendered, including payment of co-pays at the time of check-in. We will gladly provide you with a patient balance statement and an Explanation of Payment from your insurance company. We accept cash, personal check, debit card, American Express, Discover, MasterCard, and VISA. We also offer financing through CareCredit and can assist you with an application.

4. Should you arrive late for your scheduled appointment the receptionist will check with the provider who will determine if you can be seen. We reserve the right to reschedule any appointment if the patient arrives more than 15 minutes late. **There will be a $50.00 missed appointment fee for patients that do not cancel appointments.**

5. Statements indicating patient responsibility are due upon receipt. Under certain circumstances we will arrange a payment plan and require a credit card for recurring payments as established under the plan. If payment is not received after you have been sent two (2) statements you will receive a courtesy call as a reminder to submit payment; if payment is not received the account will be assigned to a collections agency. Once your account is assigned to collections we can no longer process payment from you in this office. You are responsible for the balance in full in addition to any assigned collections fees once the account is sent to our collection agency.

6. We do not accept "Starter Checks". We do not accept personal checks for payment of services at the initial visit if you are a "Self-pay" patient. We reserve the right to charge a Returned Check Fee for NSF checks. The returned check fee is $35 per occurrence (VA 8.01-27.1).

7. We retail a variety of items for the convenience of our patients. You are under no obligation to accept the item and may decline the item and purchase elsewhere. Specific items are non-reimbursable by your insurance company and are considered "Cash & Carry". We will advise you of the cost of the item you wish to purchase. Once purchased or fitted to you, you cannot return the item per OSHA regulations. These items are non-refundable.

8. As a courtesy to you, we obtain an estimate of patient responsibility and determine if services or Durable Medical Equipment we dispense to you, requires prior authorization. Please understand that the information we obtain in a Benefit & Eligibility check is not a guarantee of payment by your insurance company. You will be asked to pay your expected patient responsibility for items or services provided to you upon Check-out. You are under no obligation to accept these items or services and may formally decline to your treating provider before the treatment or item is rendered or dispensed.

9. Prescriptions for narcotics must be picked up and signed for during business hours. We cannot mail these prescriptions or call them into your pharmacy. Prescriptions for non-narcotic medication can be picked up at this office or called into your pharmacy. We request 72-hours advance notice to have your prescription ready. We do not fill prescriptions on holidays or weekends. Please request refills at the time of your appointment or have your pharmacist fax the request to the office at (703) 858-1801. Please note we do not send prescriptions to mail-order pharmacies.

10. A copy of a prescription for physical therapy, occupational therapy, labs, CT Scan, Bone Scan, MRI or EMG/NCS requires 2 business days' notice and must be picked up in person, or can be mailed to your home address. For your privacy and protection, we do not fax prescriptions and we may request verification of identity at the time of pickup.

11. In order to obtain pre-authorization necessary for your procedure (CT Scan, Bone Scan, MRI, etc) you must provide us with the location where the procedure will be conducted. We require 3-5 business days to complete authorizations. Should you change the location of your procedure, a new authorization will need to be filed.

12. All Medical Records Requests must be made using the *Authorization to Release Healthcare Information* form. Fees include $0.50 per page for up to 50 pages; $0.25 per page for 51 pages and above; $10 per x-ray DVD; plus postage and a $10 handling fee. Your copies will be available within fifteen (15) business days.

13. For completion of disability, FMLA, and other forms there will be a fee of $25 to $50 depending upon the complexity of the paperwork.

Patient/ Guarantor Signature	Relationship to Patient	Date