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_______________ _______________ _______________ _______________ _______________

PHONE (H)_______________ PHONE (W) _______________ PHONE (C) _______________ EMAIL_______________

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY ______________________ PHONE ______________

POLICY HOLDER NAME ______________________ POLICY ID # ______________

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 ID# ______________

POLICY HOLDER DATE OF BIRTH______________ POLICY HOLDER'S EMPLOYER ______________

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

AUTHORIZATION TO BILL

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.

Patient /Guardian 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 Lorenzetti, 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 **Patient /Guardian Signature**