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