



setting the pace of orthopaedic care

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PLEASE PRINT CLEARLY PATIENT INFORMATION SHEET

PATIENT'S NAME: GENDER: MALE FEMALE

MARITAL STATUS: SINGLE MARRIED DIVORCE SEPARATED WIDOWED PARTNER

RACE: WHITE BLACK HISPANIC AMERICAN INDIAN ASIAN OTHER

ETHNICITY: HISPANIC/LATINO NON-HISPANIC/LATINO

BIRTH DATE: SSN:

ADDRESS: E-MAIL ADDRESS:

CITY: STATE: ZIP: AGE: SEX:

HOME PHONE: CELL PHONE: WORK PHONE:

EMPLOYER/SCHOOL (IF STUDENT): PHONE:

ADDRESS: CITY: STATE: ZIP:

IF PATIENT IS A MINOR, PLEASE PROVIDE NAME OF PARENT(S) OR LEGAL GUARDIANS:

NAME: RELATIONSHIP TO PATIENT:

BILLING ADDRESS (IF DIFFERENT THAN ABOVE): PHONE:

ADDRESS: CITY: STATE: ZIP:

WAS THE INJURY/CONDITION INCURRED AT, OR A RESULT, OF: WORK AUTO ACCIDENT SLIP & FALL

INJURY IN/ON PUBLIC OR PRIVATE PROPERTY (OTHER THAN YOUR OWN) NONE OF THESE

DO YOU HAVE AN ATTORNEY REPRESENTING YOU IN REGARDS TO THIS INJURY? YES NO

IF YES, WHO? PHONE:

YOUR PERSONAL/PRIMARY CARE PHYSICIAN: PHONE:

ADDRESS: CITY: STATE: ZIP:

INSURANCE INFORMATION:

PRIMARY INSURANCE: INSURANCE ID #:

NAME OF POLICY HOLDER: RELATIONSHIP:

SECONDARY INSURANCE: INSURANCE ID #:

NAME OF POLICY HOLDER: RELATIONSHIP:

PHARMACY INFORMATION

PHARMACY NAME: PHONE:

ADDRESS: CITY: STATE: ZIP:

IN CASE OF EMERGENCY, NOTIFY

NAME: HOME PHONE:

RELATIONSHIP: CELL PHONE:

If the patient is over age 18, has he or she established an advance directive? YES NO DON'T KNOW

I acknowledge that I have received a copy of Asheville Orthopaedics Associates Notice of Privacy Practices.

Sign Date

COLLECTION OF DEDUCTIBLE/COINSURANCE/CO-PAYMENT FORM

Patient's Name: _____
Patient's ID Number: _____ Patient's DOB: _____
Patient's Mailing Address: _____
City: _____ State: _____ ZIP Code: _____

I will pay for my deductible/coinsurance/copayment in full today and at the time of future services [if checked, the following does not apply].

Dear Patient,

We have verified with your insurance carrier that your insurance coverage reflects a deductible balance of \$ _____. Since your insurance company has indicated that you are responsible for paying for services that fall under your deductible/coinsurance/co-payment and you have indicated that you have chosen not to pay at time of service, please check the appropriate box(es) to identify your selected payment method. Also, please indicate whether or not you have an HSA/HRA account or secondary insurance set up to help with deductible or other out-of-pocket fees.

I authorize my provider to take an imprint of my debit/credit card. I understand that my provider will submit the claim to my insurance carrier on my behalf. Upon AOA's receipt of notification from my primary or secondary [if applicable] insurance carrier that I am responsible for any applicable deductible/coinsurance/copayment, I authorize my provider to charge my debit/credit card for any balances owed on services rendered.

I have access to funds available through an HSA [Health Savings Account], HRA [Health Reimbursement Account, FSA [Flexible Spending Account] or secondary insurance coverage that will cover all or part of my deductible/ coinsurance/co-payment and I will use, to the extent available, these funds to pay any and all outstanding balances on my account when due.

Please check one of the following:

I have a HRA/HSA debit/credit card and authorize my provider to take an imprint of my card with the following understanding: My provider will submit the claim to my insurance carrier on my behalf. Upon AOA's receipt of notification from my primary or secondary [if applicable] insurance carrier that I am responsible for any applicable deductible/coinsurance/copayment, I authorize my provider to charge my debit/credit card for my balance. I understand that I am personally responsible for any balances in excess of those available funds and will promptly pay according to my financial agreement with AOA.

I do not have a HRA/HSA credit card associated with my insurance coverage and, in lieu of payment at the time of services rendered, will commit to the following: Upon AOA's receipt of my Explanation of Benefits from my primary or secondary [if applicable] insurance carrier, I understand that I am responsible for any applicable deductible/coinsurance/ co-payment and I must provide payment directly to my provider within **10 days** of AOA's receipt of the EOB. I also understand that this financial commitment is not dependent on a billing statement from my provider and any unpaid balance is subject to my financial agreement with AOA.

My provider and I have agreed to a financial arrangement/payment plan to pay for any applicable outstanding balance.

If I do not pay in accordance with that agreement, I understand my provider may seek alternative methods to collect these monies, including collection and legal action. As well, I understand that any surgery, non-covered services, or high-cost procedures or equipment may fall into a separate payment arrangement and that I may be asked to pay a deposit toward these services.

I understand that I am responsible for paying my provider directly for any applicable deductible/coinsurance/ co-payment. This is a contractual requirement when receiving healthcare services. I understand that if I do not fulfill this requirement, my provider may notify my insurance carrier and seek alternative methods of collection. Failure to meet my obligations is a violation of my agreement with my insurance carrier and the carrier may take additional action. I understand that AOA may, at anytime, elect to charge the maximum interest allowed by state law on any outstanding balance. I further understand that if my provider collects any applicable deductible/coinsurance/ copayment from me and is also reimbursed directly from my insurance carrier, that I will be reimbursed from my provider any overpayment owed to me no later than 60 days after the provider's receipt of insurance carrier notification.

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____



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HIPAA Authorization to Disclose Protected Health Information

This authorization to release health information is for:

Patient Dependent child Other (Please check one)

Name: _____

The following health information may be disclosed:

Medical Other

If other, please explain: _____

The following health information may NOT be disclosed:

HIV Hepatitis Other

If other, please explain: _____

The following person(s) or group(s) may receive the health information designated above:

1. _____
2. _____
3. _____

I hereby authorize the use and/or disclosure of my individual identifiable health information as described above. *I understand that this authorization is voluntary.* I also understand that if the person or organization authorized to receive the information is not a health plan or health care provider, the released information may be further disclosed and may no longer be protected by the federal privacy regulations.

Signature of Individual Authorizing Release of Information Date

Print Name

If signed by an individual's authorized representative, describe the representative's authority:

- Member is a minor; I am the member's parent or legal guardian.
- Member is deceased; I am the member's surviving spouse or the executor/administrator of the member's estate.
- I am the Member's agent, as designated in the member's Durable Power of Attorney for Health Care.
- Other - describe: _____

Your Rights:

You may revoke this Authorization at any time by providing written notice to

Asheville Orthopaedics Associates

ATTN: Medical Records

111 Victoria Rd. Asheville, NC 28801.

Your revocation will not affect any actions already taken in reliance on this authorization.

You are entitled to receive a copy of this authorization upon request.

You may inspect or copy any information to be used or disclosed under this Authorization.