WINDWARD ORTHOPAEDIC GROUP, INC - PATIENT INFORMATION SHEET

PATIENT NAME: _____ **Sex:** ___**M** ___**F**

DOB: _____/_____/_____ **SS#:**_____ **MARITAL STATUS:** ___**Single** ___**Married** ___**Widow**

PRIMARY PHONE: _____ **SECONDARY PHONE:** _____

HOME ADDRESS: _____ **City/State**_____ **Zip Code:** _____

MAILING ADDRESS: _____ **City/State**_____ **Zip Code:** _____

EMAIL: _____ ***(Or Check here if None_____)***

**Initial here to authorize leaving messages on primary phone regarding communication of my healthcare/treatment such as instructions for procedures, clinical, billing and/or appointment needs: _____

GUARANTOR (Responsible Party): __**Self** ___**Other (If *other* selected OR if patient is a minor, complete guarantor info below)**

Name: _____ **DOB:** ___/___/____ **PHONE:** _____

ADDRESS: _____

IF PATIENT IS A MINOR

(Please complete both father & mother information)

Father's Name: _____ **Mother's Name:** _____

DOB: _____ **SS#:** _____ **DOB:** _____ **SS#:**_____

Home#: _____ **Cell #:** _____ **Home#:** _____ **Cell #:**_____

PRIMARY CARE PHYSICIAN: _____ **REFERRED BY:** _____

PHARMACY _____ **LOCATION/ADDRESS:** _____

****Initial here to approve download of medications from pharmacy: _____

EMPLOYMENT INFORMATION

EMPLOYER: _____ **OCCUPATION:** _____ **WORK #:**_____

ADDRESS: _____ **City/State:** _____ **Zip Code:** _____

WORKERS' COMP. INFORMATION ONLY

CLAIM #: _____ **DATE OF INJURY:** _____/_____/_____

ADJUSTOR NAME: _____ **PHONE #:** _____ **FAX #:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ **Policy No:** _____ **Coverage/Plan Code**_____

SUBSCRIBER: _____ **DOB:** _____ **SS#**_____ **Relationship to patient**_____

SECONDARY INSURANCE: _____ **Policy No:** _____ **Coverage/Plan Code**_____

SUBSCRIBER: _____ **DOB:** _____ **SS#**_____ **Relationship to patient**_____

IN CASE OF EMERGENCY

Contact: _____ **Work Phone:** _____ **Home Phone:** _____

Cell: _____ **Relationship to patient:** _____

***AGREEMENT:** The information provided is true and accurate. I understand that the insurance carrier may require information regarding treatment in order to evaluate and administer claims and I authorize release of such information as necessary. I authorize the insurance

carrier to pay the provider directly for services rendered. I agree to be ultimately responsible for payment of services rendered, and in the event that my account becomes delinquent, I agree to be responsible for any collection costs incurred. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for all services rendered to the patient herein.
Signature: _____ Date: _____

Print: _____ Relationship: _____

PRIVACY POLICY INFORMATION

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. COPY OF THIS PRIVACY POLICY IS AVAILABLE UPON REQUEST.

OUR PRIVACY POLICY WINDWARD ORTHOPAEDIC GROUP, INC IS COMMITTED TO KEEPING THE SECURITY AND CONFIDENTIALITY OF PERSONAL INFORMATION THAT YOU PROVIDE TO US. WE TAKE OUR RESPONSIBILITY OF SAFEGUARDING YOUR INFORMATION SERIOUSLY. WE DO NOT SELL OR SHARE CUSTOMER INFORMATION WITH MARKETING GROUPS OUTSIDE OF WINDWARD ORTHOPAEDIC GROUP, INC AND ITS AFFILIATE GROUPS.

THIS POLICY COVERS PATIENT INFORMATION, INCLUDING PERSONAL FINANCIAL OR HEALTH INFORMATION ABOUT A PATIENT OR PATIENT RELATIONSHIP. WE ARE DISCLOSING THIS POLICY AS REQUIRED BY FEDERAL AND STATE REGULATIONS. IF, AFTER READING THIS NOTICE, YOU HAVE QUESTIONS OR CONCERNS, PLEASE ASK TO SPEAK WITH THE OFFICE MANAGER.

INFORMATION WE MAY COLLECT WE COLLECT AND USE SEVERAL KINDS OF INFORMATION IN ORDER TO PROVIDE YOU WITH MEDICAL SERVICES TO BETTER SERVE YOU. THE TYPES OF INFORMATION WE MAY COLLECT CAN BE CATEGORIZED AS FOLLOWS: • INFORMATION WE RECEIVE FROM YOU ON FORMS; AND • INFORMATION ABOUT YOUR TRANSACTIONS WITH US OR WITH OUR AFFILIATED THIRD PARTIES • INFORMATION WE SHARE WITH MEDICAL AFFILIATES • INFORMATION WE SHARE WITH NON-AFFILIATED THIRD PARTIES NON-AFFILIATED THIRD PARTIES ARE COMPANIES NOT CONTROLLED BY WINDWARD ORTHOPAEDIC GROUP, INC (NO NON-PUBLIC PERSONAL HEALTH OR FINANCIAL INFORMATION ABOUT PATIENTS OR FORMER PATIENTS IS SHARED WITH THESE NON-AFFILIATED THIRD PARTIES BEYOND WHAT IS NECESSARY TO PROVIDE YOU SERVICES OR AS PERMITTED BY LAW. WE DO NOT SELL ANY OF YOUR INFORMATION TO PERSONS OR ORGANIZATIONS OUTSIDE OF WINDWARD ORTHOPAEDIC GROUP, INC). • OTHER NECESSARY DISCLOSURES OF INFORMATION WE MAY ALSO DISCLOSE ANY INFORMATION WE COLLECT WHEN PERMITTED OR REQUIRED BY LAW. FOR EXAMPLE, THIS MAY INCLUDE, BUT IS NOT LIMITED TO, DISCLOSURES RELATED TO A COURT SUBPOENA OR OTHER SIMILAR LEGAL REQUESTS, FRAUD INVESTIGATIONS, OR AN AUDIT OR SECURITY EXAMINATION.

PROTECTING CUSTOMER INFORMATION WE TAKE EVERY MEASURE TO LIMIT ACCESS TO NON-PUBLIC PATIENT INFORMATION TO THOSE EMPLOYEES WINDWARD ORTHOPAEDIC GROUP, INC, WHO NEED TO KNOW THE INFORMATION TO PROVIDE SERVICES TO YOU OR ANSWER YOUR QUESTIONS. WE WILL COMPLY WITH REGULATIONS TO PROTECT YOUR NON-PUBLIC PERSONAL INFORMATION.

YOU DO NOT NEED TO SEND WINDWARD ORTHOPAEDIC GROUP, INC AN "OPT-OUT" FORM IT IS NOT NECESSARY FOR PATIENTS TO SEND WINDWARD ORTHOPAEDIC GROUP, INC WRITTEN REQUESTS ASKING US NOT TO SHARE THEIR PERSONAL INFORMATION (KNOWN AS AN "OPT-OUT" FORM) BECAUSE: WE DO NOT AND WILL NOT SELL OR SHARE PATIENT INFORMATION FOR MARKETING PURPOSES OUTSIDE WINDWARD ORTHOPAEDIC GROUP, INC. NO NON-PUBLIC PERSONAL HEALTH OR FINANCIAL INFORMATION ABOUT PATIENTS OR FORMER PATIENTS IS SHARED WITH NON-AFFILIATED THIRD PARTIES BEYOND WHAT IS NECESSARY (E.G., TO PROCESS CLAIMS) TO PROVIDE YOU WITH MEDICAL SERVICES AS PERMITTED BY LAW.

***I ACKNOLWEDGE I HAVE READ & UNDERSTAND THE PRIVACY POLICY: _____**

FINANCIAL AGREEMENT

Patients are responsible for knowing which provider(s) are participating with their insurance carrier.

Participating Insurances: Valid health insurance information must be provided to us to ensure appropriate reimbursement for your care. We participate with the most major medical plans. If your insurance does not pay 100%, you will be responsible for any deductible, co-payment, coinsurance, and any non-covered services.

Non-Participating Insurances: We do not participate with Ohana Quest or United Healthcare Quest.

Workers Compensation / Auto Insurance: We will submit claims to a valid carrier. If you have health insurance, you will be required to provide the information to us in case your WC/Auto benefits are denied or exhausted. All remaining balances or denied services will be your responsibility.

Referrals/Authorizations: It is your responsibility to ensure we have the required referral and/or authorization for treatment to your visit. If you do not have the required referral and/or authorization your appointment will be rescheduled.

Co-Pays: Co-pays are due at the time of service.

Self-Pay: If you do not carry insurance - payment is expected at time of service for any incurred charges.

Collections: Any patient that has been placed in collections must pay any outstanding balances owed along with the collection agency fee before an appointment will be scheduled.

Form Completion: Most forms are completed within 7-10 business days. A payment of $10 per form is required when dropping off forms.

Payment Plans: Our office will be happy to work with you in order to pay any balance due to our practice.

Payment Methods: We accept cash, check, MasterCard or VISA. You may also pay your bill online at www.windortho.net.

***I ACKNOWLEDGE I HAVE READ & UNDERSTAND THE FINANCIAL AGREEMENT: _____**