EMPIRE
ORTHOPAEDICS

Co-Payment Policy

According to the regulations of individual insurance carriers, patients are responsible for paying co-payments at the time of each office visit.

EMPIRE ORTHOPAEDICS

PAYMENT POLICY FOR SERVICES RENDERED

- **If You Have Health Insurance:** Please **Initial** the Line Next Your Insurance in **Section 1, 2 or 3**.
- **If You Do Not Have Health Insurance**: Please Read **Section 4**.
- **Everyone:** Please **Sign** at Bottom of Form and give your card (if applicable) to the Receptionist so we may make a copy for your file.

1. **IF YOU HAVE INSURANCE WITH ONE OF THE FOLLOWING INSURANCE COMPANIES**, please initial the appropriate line. We will bill these companies directly and will follow up on outstanding balances. You will be responsible for payment of your designated co-pay at each visit to the office BEFORE you see the doctor. You are responsible to present updated referral authorizations from your insurance carrier when required.

____ Medicare	____ Tricare	____ Empire BCBS	____ BCBS NY Excellus	___ Multiplan
____ Medicaid	____ United Healthcare	____ Independent Health	____ Atlantis IPA	___ Preferred HealthCare
____ Magna Care	____ AETNA	____ GHI	____ BCBS of Western NY	___ Univera
____ Cigna	____ Healthnow	____ MVP	____ Rail Road Medicare	

2. **IF YOU HAVE BEEN INJURED ON THE JOB AND YOUR EMPLOYER HAS WORKERS' COMPENSATION COVERAGE**, we must have information approving the claim from your employer and an accurate billing address to send the claim to for processing. Without this, we will consider payment for this visit to be your responsibility. Empire Orthopaedics follows the New York State Workers Compensation fee schedule and is not a member of any Workers' Comp PPO's.

Name of Insurance Company: _____ Contact Person: _____

Address: _____ Phone: _____

3. **IF YOU HAVE COVERAGE WITH INSURANCE COMPANY, NOT LISTED ABOVE.** If you provide us with a copy of your card, we will submit a claim directly to your insurance company for reimbursement as a courtesy. Please review the following procedure and sign.

"I understand that my services are being billed directly to my insurance carrier for me. The insurance company should send payment directly to me (the patient). If the payment is received at our office the payment will be forwarded to the patient. I understand that it is my responsibility to follow up with my insurance company. I understand that this entire balance is at all times my responsibility."

Insurance Co Name: _____ Signed: _____ Date: _____

4. **IF YOU DO NOT HAVE HEALTH INSURANCE,** you are responsible for payment of your bill at the time of your visit. We accept personal checks, credit cards, and cash. A payment of $50.00 is due before your visit. The balance will be due when your visit is complete. If your bill exceeds $200.00, a payment plan can be worked out at the time of the visit. Please ask for our payment agreement form.

"I understand and agree that regardless of my insurance coverage, I am responsible for the balance of this account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance status. I also agree that if I am unable to pay my bill promptly, I will call the billing department to make timely payment arrangements. I understand that if my account becomes delinquent and Empire Orthopaedics incurs any collection charges, they will be my responsibility."

If the patient is a minor: **"By consenting to care at Empire Orthopaedics, I am agreeing that I will take responsibility for the payment of the medical bills. I will provide the office with all information necessary and will communicate with the office regarding any changes in responsibility.**

Patient or Guardian Signature_____ Date_____

EMPIRE ORTHOPAEDICS

Restore Your Freedom of Movement

Notice of Health Information Practices Summary

Your Medical Record Each time you visit a hospital or physician, a record is made of your visit. This information, commonly known as a medical record, contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care. The confidentiality of your medical record is protected under the State-specific and Federal law.

Your Health Information Rights Your medical record is the physical property of the physician or healthcare facility that compiled it, but the information belongs to you. Therefore, you have rights regarding the use and disclosure of your health information.

Our Responsibilities *Empire Orthopaedics* is required by the Federal Privacy Rule to maintain the privacy of your medical record and to provide you with a notice of our legal duties and privacy practices.

Uses and Disclosures for Treatment, Payment, and Health Care Operations *Empire Orthopaedics* will use your health information in order to treat you. We will provide other providers or hospitals with copies of your medical record to assist them in treating you, should that become necessary. We will also use and disclose health information about you to make appointments with you.

Empire Orthopaedics will use your health information for payment. The information on a bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Empire Orthopaedics will use your health information for regular health operations to assess the quality of your care.

Empire Orthopaedics will disclose your health information to business associates, such as a medical transcription or billing service; so that they can perform the job we have asked them to do.

Uses and Disclosures that We May Make Unless You Object You have the right to object to certain situations in which *Empire Orthopaedics* may disclose information from you medical record.

Disclosures Permitted without Consent *Empire Orthopaedics* is required by state and Federal law to disclose health information from your medical record under specific circumstances.

Uses and Disclosures Specifically Authorized by You *Empire Orthopaedics* expects to make other uses and disclosures of your protected health information only on the basis of specific written authorization forms signed by you.

To Report a Problem You have the right, under Federal law, to report a problem or file a complaint about how your personal health information is being handled. You can do this directly with *Empire Orthopaedics* or to the Secretary of Health and Human Services in Washington, D.C.

Empire Orthopaedics will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care.

We have prepared a detailed *Notice of Privacy Practice* to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our office and have copies available for distribution.

Notice of Health Information Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Understanding Your Health Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, which we refer to as your health or medical record, is an essential part of the health care we provide for you. It serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you receive
- Means by which you or a third-party payer can verify that services billed were actually provided
- Tool for educating health professionals
- Source of data for medical research
- Source of information for public health officials charged with improving the health of the nation
- Source of data for facility planning and marketing
- Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Your health record contains personal health information, the confidentiality of which is protected under both state and federal law. Understanding we expect to use and disclose your health information helps to:

- Ensure its accuracy
- Better understand who, what, when, where, and why you health care providers and others may access your health information, and
- Make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. Under the Federal Privacy Rules, 45 CFR Part 164, you have the right to:

- Receive notice of the uses and disclosures we expect to make of your health information, including a paper copy of the notice if requested, as provided in Rule 520.

- Request additional restrictions on uses and disclosures of your health information *(though we are not required to agree to any such request)*, or request that we send you confidential communications by alternative means or at alternative locations, as provided in 45 CFR 164.522.

- Inspect and obtain a copy of your health record as provided in 45 CFR 164.526.

- Obtain an accounting of disclosures of your health information made after April 14, 2003, for purposes other than treatment, payment or health care operations, as provided in 45 CFR 164.528.

Please direct requests to:
Empire Orthopaedics
55 Spindrift Drive
Suite 120
Williamsville, NY 14221

Our Responsibilities

We are required by the Federal Privacy Rules to:

- Maintain the privacy of your health information

- Provide you with a notice as to our legal duties and privacy practices with respect to health information we collect and maintain about you.

- Abide by the terms of this notice, subject to the following reservation of rights.

We reserve the right to change our health information practices and the terms of this notice, and to make the new provisions effective for all protected health information we maintain, including health information created or received prior to the effective date of any such revised notice. Should our health information practices change, we will post and/or provide a revised notice. We will not use or disclose your health information without your consent or authorization, except as described in this notice.

Uses and Disclosures for Treatment, Payment, and Health Operations, Based on Your Consent

We will use your health information for treatment

For example: Information obtained by a nurse, physician, or other member of the practice will be recorded in your medical record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations to the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide subsequent healthcare providers with copies of various reports that should assist him or her in treating you. We may also send relevant portions of your medical record to specialists to whom you are being referred for care, or to physicians whom your providers here may want to consult on a care issue.

We may use and disclose health information about you (for example, by calling you or sending you a letter or card) to remind you that you have an appointment with us for treatment or that it's time for you to schedule a regular checkup with us, or to provide you with information about treatment alternatives.

We will use your health information for payment

For example: A bill may be sent to you or your insurance company or health plan. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations

For example: Members of the practice or members of a quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates

We provide some services with business associates, who are independent professionals that use patient health information provided by us in order to perform these services. Examples include a billing service and an answering service. When these services are contracted, we may disclose your health information to our business associate so that that they can perform the job we have asked them to do and bill you or your insurer for services rendered. To protect your health information, we require the business associate to appropriately safeguard your information.

Uses and Disclosures that We May Make Unless You Object

Family or friends involved in care: Unless you object in writing, health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Marketing and fundraising: We may use or disclose your health information in connection with limited marketing or fundraising communications as permitted under the Federal Privacy Rules. Any such communication addressed to you will contain instructions describing how you may "opt out" of receiving further such communications.

Required Disclosures

The Federal Privacy Rules requires us to disclose your personal health information in two instances:

1. To you at your request under 45 CFR 164.524 or 45 CFR 164.528 and
2. To the Secretary of Health and Human Services when requested as part of an investigation or compliance review under 45 CFR 164.502.

Disclosures Permitted Without Consent for National Priority Purposes

In addition, 45 CFR 164.512 permits uses and disclosure of your health information without your consent or authorization for certain "national priority" purposes, including:

- When required by state or federal law
- To state and federal public health authorities, including state medical officers, the Food and Drug Administration (FDA), and other agencies charged with preventing or controlling disease.
- To government authorities, including protective service agencies, authorized to receive reports of abuse, neglect, or domestic violence.
- To government health oversight agencies, such as the state and federal Departments of Health and Human Services, Medicare/Medicaid Peer Review Organizations (PRO's), state Boards of Medicine, Nursing, and Pharmacy, and other licensing authorities.
- When required by court order in a judicial or administrative proceeding.
- To law enforcement officials for certain law enforcement purposes, including the reporting of certain types of wounds or injuries, or pursuant to a warrant, subpoena, or other legal process, or for the purpose of identifying or locating a subject, fugitive, material witness, missing person, or victim, provided that the conditions in the rule are met.
- To coroners, medical examiners, or funeral directors for purposes of identifying a deceased person or carrying out their duties as required by law.
- To organ procurement organizations for purposes of organ or tissue donation and transplantation, consistent with applicable law.
- For research approved by an Institutional Review Board (IRB) or Privacy Board that has reviewed the research protocol and established protocols to ensure the privacy of your health information.
- When required to avert a serious threat to health or safety.
- When requested for certain specialized government functions authorized by law, including military and similar situations.
- As authorized by law in connection with workers compensation programs.

Uses and Disclosures Specifically Authorized by You

We expect to make other uses and disclosures of your protected health information only on the basis of specific written authorization forms signed by you. You have the right to revoke any such authorization at any time, except to the extent we have already relied on it in making an authorized use or disclosure.

For More Information or to Report a Problem

If you have any questions, you may contact the office of Empire Orthopaedics.

If you believe your privacy rights have been violated, you can file a complaint with the Secretary of Health and Human Services at the Department of Health and Human Services, Office of the Secretary, 200 Independence Avenue, S.W. Washington, D.C. 20201; telephone 202-690-7000

Effective Date: January, 2012

EMPIRE ORTHOPAEDICS

Restore Your Freedom of Movement

Billing and Registration Form

LASTNAME _____ FIRST NAME_____

DATE OF BIRTH ___/___/____ SOCIAL SECURITY #_____-____-_____ SEX (M / F) MARITAL STATUS_____

MAILING ADDRESS_____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE # _____ FORMER NAME(S) _____

EMERGENCY CONTACT & PHONE _____

EMPLOYER INFORMATION:

COMPANY NAME _____ WORK PHONE _____ EXT _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

BILLING INFORMATION:

NAME OF RESPONSIBLE PARTY (if other than self) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

RELATIONSHIP _____ DATE OF BIRTH ___/___/_____ PHONE NUMBER _____

INSURANCE INFORMATION/WORKERS COMP INFO:

Please give your card to the receptionist to copy

IS CONDITION RELATED TO EMPLOYMENT?_____ AUTO ACCIDENT?_____ OTHER ACCIDENT?_____

DATE OF INJURY _____ TIME OF INJURY _____

INSURANCE 1 _____ **COPAY AMOUNT** _____

SUBSCRIBER NAME _____ RELATIONSHIP_____

CERTIFICATE # _____ GROUP # _____

INSURANCE 2 _____ **COPAY AMOUNT** _____

SUBSCRIBER NAME _____ RELATIONSHIP _____

CERTIFICATE # _____ GROUP # _____

SUBSCRIBER DATE OF BIRTH (IF DIFFERENT THAN SELF) ___/___/_____ SOCIAL SECURITY # _____-_____-_____

I authorize the release of any medical information necessary to process this claim. (REQUIRED) Signature_____ Date _____	I authorize payment of medical benefits to my physician for services provided. (REQUIRED) Signature_____ Date _____

EMPIRE ORTHOPAEDICS

55 Spindrift Drive Suite 120 Williamsville, NY 14221

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

SS#: _____ Patient's phone #: ( ) _____

Date of Request: _____ **Date Needed:** _____

OR

☐ I authorize Empire Orthopaedics **to release information to**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

☐ I authorize Empire Orthopaedics **to obtain information from**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one.) ☐ Healthcare ☐ Insurance coverage ☐ Personal ☐ Other ☐ Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one.)

☐ All medical records related to a specific illness or injury**.**

_____
Specify illness/injury Date(s) of treatment

☐ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)

☐ Specific information (Select one or more, as applicable)

☐ Procedure report ☐ History & physical ☐ Physical Therapy ☐ Laboratory test results

☐ X-ray reports ☐ Other _____
(Please describe.)

☐ Entire copy of the record checked above.

AUTHORIZATION VALID FOR: (Check one.)

☐ This request only.

☐ One year from the date of this authorization **OR** _____ . (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.

☐ This request **and** for medical records of any **future** treatment of the type described above until: _____
Insert Date

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative _____ Date _____

Relationship to Patient *(if requester is not the patient)* _____

Workers' Compensation/No-Fault
State of New York
Questionnaire

Account#_____

Name_____ Date_____

Address_____

Date of Birth_____ SS #_____

Home Telephone_____ Alternate Telephone_____

Referred by_____ Date of Injury_____

Treating Physician_____ Family Care Practitioner_____

Nature of Injury/Injuries_____

X-rays (Y/N) _____ MRI (Y/N) _____ Other imaging _____

Employer Information:

Name_____

Address_____

Phone_____ Date Reported to Employer_____

Insurance Information:

Carrier_____

Address_____

Phone_____Fax_____Claim Representative_____

WCB Case#_____ Carrier Case #_____

Patient Private Health Insurance: _____Telephone#_____

ID#_____ Group #_____