PATIENT REGISTRATION FORM

(Please Print) FILL OUT COMPELETLY

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle:**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status (circle one)** Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	**If not, what is your legal name?**	(Former name):	**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F

Physical Address:	**Social Security # REQUIRED:**	**Email:**

Mailing Address:	**State:**	**ZIP Code:**	**Preferred Pharmacy:** **Primary Care Physician:**

Home Phone #: ( )	**Cell phone #:** ( )	**EMPLOYER:** **Work phone #: ( )**

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Family or Friend ❑ Hospital

Able to leave a detailed message on numbers provided? YES NO (please circle one)

GUARANTOR AND INSURANCE INFORMATION

Patient/Responsible Party Information: ❑**Self (Leave Blank)** ❑**Parent of Child** ❑**Other:**_____

Name:	Birth date: / /	Address (if different):	City/State:

Social Security #:	Home #:	Cell #:	Work #:

Is this patient covered by insurance? ❑ **Yes** ❑ **No**

Please indicate primary insurance:

Subscriber's name:	Birth date: / /	Group #:	Policy #:	**Social Security #:**

Patient's relationship to subscriber: ❑ **Self** ❑ **Spouse** ❑ **Child**

Name of secondary insurance (if applicable):	Subscriber's name: Date of Birth: / /	Group #:	Policy #:

Patient's relationship to subscriber: ❑ **Self** ❑ **Spouse** ❑ **Child** **Social Security #:**

IN CASE OF EMERGENCY

Name of Emergency Contact: **Mailing Address:**	**Relationship to patient:**	**Home #:** **Work#:**	**Cell #:**

I hereby give lifetime authorization for payment of insurance benefits to be made directly to KENAI PENINSULA ORTHOPAEDICS, and any assisting physicians for services rendered. I understand that I am finically responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections and reasonable attorney's fees. I Hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ _____

Patient/Guardian signature ***Date***

DOUBLE SIDED

HIPAA, Acknowledgement of Patient Privacy Notification:

The purpose of the form is to acknowledge your consent for treatment, authorization for billing and the conditions under which your medical information may be used.

- The undersigned consents to the examination and procedures as outlined by his/her physician, including any emergency treatment or services, x-ray examinations, and/or surgical procedures rendered.
- The undersigned authorizes, whether he/she signs as agent or patient, direct payment to Kenai Peninsula Orthopaedics of any insurance benefit billed on behalf of the patent or otherwise payable of services rendered.
- I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES ASSOCIATED WITH MY MEDICAL TREATMENT.
- I understand that insurance claims billed on my behalf are strictly a courtesy provided by KPO (except for Medicare, Medicaid, and Worker's Compensation).
- I agree that a photocopy of this form may be used in lieu of an original, and I allow a Fax transmittal of medical information, if needed, and agree to have my medical records released as needed.
- Kenai Peninsula Orthopaedics does utilize the services of a collection agency, and I agree to pay all reasonable attorney's fees and collection cost in the event of default of payment.
- I understand the circumstances under which my medical record information may be released without my expressed consent.
- I understand that the Patient Privacy Notice gives full disclosure of how KPO may use my medical information. You have the right to a paper copy of the Patient Privacy Notice and may ask us to give you a paper copy of this Notice at any time.

Acknowledgement and Agreement to Financial Policy:

This form is used to acknowledge understanding and agreement with the terms of Kenai Peninsula Orthopaedics Financial Policy.

- Full payment is expected at the time of service if you are private pay (PVP).
- We accept Visa, MasterCard, American Express, Debit Card, checks, and cash.
- We will require a 20% down payment on all scheduled surgeries if you are PVP.
- We are preferred providers with Blue Cross Insurance, but will require your copay or 20% to be paid at the time of service unless you are double covered.
- We accept and will bill the following programs: Medicare, Medicaid, Denali Kid Care, and Alaska Workers Compensation. **Patients with VA or Alaska Native Health coverage must obtain authorization prior to being seen.**
- We will courtesy bill primary and secondary insurance. **We do not bill automobile insurance** unless prior arrangements have been made with our billing office.
- We will assist those with documented financial needs to make payment arrangements, if possible. Details provided on payment arrangement form.
- Patients that no-show or cancel within 24 hours will be charged a $25.00 fee.
- Account statements that show patient and insurance company responsibility and activity are sent monthly or once we receive a response from the insurance company.
- Accounts that are 90 days or more past-due and have not had any activity may be sent to a collection agency.

- We will charge a $25.00 NSF Fee for all checks returned by your banking facility.
- I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES ASSOCIATED WITH MY MEDICAL TREATMENT.

_____ I give permission to Kenai Peninsula Orthopaedics to provide, on my behalf, any and all documentation to my insurance carrier to appeal partially paid and/or denied medical services.

I have read, fully understand the above and have received and/or have been offered a copy of this document.

Patient Name (Printed): X _____ Date: _____

Signature of Patient, Guardian, or Legal Representative: X _____

KPO Employee Witness: _____