## AUTHORIZATION AND RELEASE

Authorization for treatment, benefits and release of Medical Records to: (please initial on line provided)

_____Employer _____PCP _____Referring MD

_____Physical Therapy _____Attorney _____DME Supplier

I understand New Hampshire Orthopaedic Center will, as a courtesy to me, bill my insurance company for services rendered and send a monthly statement to me. I also give permission to release any medical information necessary to my insurance company. I understand New Hampshire Orthopaedic Center will retain a copy of my driver's license in an effort to safeguard the use of my health information and insurance against fraud and abuse.
I understand if services rendered from the initial visit to present are non-referred/non-covered services, I will be responsible for payment. I accept full responsibility for all services that have not been authorized by my physician or insurance company.
I agree to pay my balance with New Hampshire Orthopaedic Center if either my Workers' Compensation claim is denied, my MedPay/PIP is exhausted, my private health insurance does not cover services or if my legal case is not settled in my favor.

**I also understand I am ultimately responsible for any balance on this account. Any patient balance over 90 days will be sent to collection.**
I authorize payment of all claim forms directly to New Hampshire Orthopaedic Center. I understand if my health plan has a copay option, I am responsible to pay at the time of service or my appointment will be rescheduled.

SIGNED:_____DATE:_____

## FINANCIAL POLICY

(Effective 1/1/10, updated 10/1/16)

**Insurance**
We participate with most of the major health plans in the area. Please ask us if you are unsure whether we participate with your plan. We will bill your insurance carrier as a courtesy to you; however payment for deductible and co-pay is due at the time of service. This includes all office visits, procedures, and injections. **If you do not have your co-pay with you, your appointment may be rescheduled**. Please remember your insurance coverage is a contract between you and your insurance company and not a substitute for payment.

If you are being treated for an injury sustained in a motor vehicle accident (MVA) you will be required to provide proof of health insurance coverage or pay in full at the time of service. We can no longer bill your MVA carrier for services rendered.

**Referrals**
If your insurance has designated a primary care physician (PCP) you are required to have authorization from your PCP prior to your visit. **If authorization is not provided, you will be asked to either reschedule your appointment or pay for your visit in full at the time of service**.

**Self-Pay Accounts**
Self-pay accounts are patients that have no insurance coverage, or are covered by plans we do not participate with. Payments must be made at the time of service. **If you do not have your payment with you, your appointment may be rescheduled**.

**Payment Policy**
Payments are expected at the time of service. We accept Visa and MasterCard, American Express, Discover, personal checks, and cash. For those that qualify, payment plans may be available for services not covered by insurance when arrangements are made in advance. Please expect to pay any balances due at the time of service. **If you are not able to pay your past due balance at the time of service your appointment may be rescheduled**.

**Delinquent Accounts**
In the event that your account should become delinquent, an outside collection agency may be utilized and collections fees assessed to the balance on your account. Delinquent accounts may be reported to the major credit bureaus.

SIGNED:_____DATE:_____

## Durable Medical Equipment (DME) Notice

Durable Medical Equipment, or "DME", is equipment that is primarily and customarily used to serve a medical purpose, can withstand repeated use, and is appropriate for use in the home. Examples of DME include walkers, wheel chairs, arm slings, and braces. They are generally special equipment prescribed by physicians for home use, or use outside the physician's direct supervision, that provides therapeutic benefits or helps patients perform tasks they would otherwise not be able to accomplish. Durable Medical Equipment facilitates ordinary daily activities and improves a patient's quality of life.

You are receiving this notice because your physician may provide you with equipment classified as DME and that he/she feels is medically necessary to the improvement of your condition. The DME you may receive will be billed to the appropriate party through the format set up in your patient account. Please be sure to contact your insurance company if you have any concerns or questions about the coverage of this equipment under your plan. While the majority of insurance plans cover DME, *your plan may have separate deductibles or restrictions.* While our office makes every attempt to verify your coverage and benefits, we do not make determinations of care based on an out of pocket cost you might encounter.

In the event your equipment malfunctions or is not working properly, please alert your physician at once. We cannot accept returns of any DME products.

SIGNED:_____DATE:_____

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

My signature below confirms I have reviewed or have been provided the opportunity to review New Hampshire Orthopaedic Center's Notice of Privacy Practices which informs me of the uses and disclosures of my protected health information by New Hampshire Orthopaedic Center and my rights under HIPPA.I authorize New Hampshire Orthopaedic Center to discuss my confidential health care information as follows: Please contact me by phone during the day at:

**Primary phone number:** _____-_____-_____ Pls circle: **HOME WORK CELL** Ok to leave message? **YES / NO**
**Secondary phone number:** _____-_____-_____ Pls circle: **HOME WORK CELL** Ok to leave message? **YES / NO**

**Emergency Contact**: (this *may* or *may not* be someone we can share your confidential health information with)

**Name**:_____ **Relationship**:_____ **Phone**:_____-_____-_____ Ok to share information? **YES /NO**

Furthermore, I authorize New Hampshire Orthopaedic Center to share confidential health information about me with the following individuals:

**Name**:_____ **Relationship**:_____ **Phone:** _____-_____-_____
**Name**:_____ **Relationship**:_____ **Phone:** _____-_____-_____

SIGNED:_____DATE:_____

PRINT NAME IF DIFFERENT THAN PATIENT _____

## CONSENT TO OBTAIN PRESCRIPTION HISTORY

I hereby provide my consent for New Hampshire Orthopaedic Center to obtain my prescription history using the SureScripts-RxHub network. I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx Hub has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system-to-system communications.

SIGNED:_____DATE:_____

# MEDICAL HISTORY