Thank you for scheduling with our office.

If you are a **NEW patient or have not been seen in the office in 2+ years**:

- Please complete the forms attached.
- Please arrive to your appointment between 10-15 minutes early with these forms **completed**, your insurance cards and photo id.
- Also be sure to bring your co-pay at this time.
- If you have had any diagnostic studies performed such as x-rays, MRI's, EMG's, etc **you MUST bring in the copies of these tests at the time of your appointment as well as a CD of the images.**
    - Failure to do so may result in your appointment being rescheduled or these tests may need to be repeated.

If you need to reschedule your appointment, please call our office at **419-427-1984**, press **224**.

If you have any questions please feel free to call. Thanks and have great day.

Please be sure to check out our new patient portal by clicking on the blue patient portal button at the top right of the website.

- On the portal you can request appointments and pay your bills online. Check it out today!

Thank you

Northwest Ohio Orthopedics and Sports Medicine

Northwest Ohio Orthopedics & Sports Medicine, Inc.

Patient Information (Please print and use in pen)

Legal Last Name:	Legal First Name:	Middle Name:			SSN:
Mailing Address:	City:	State:	Zip:	Email Address:	
Preferred Contact Phone Number:	Cell Phone:	Other Phone:	Gender: □ M □ F	Status: □Married □Single □Widowed □Divorced	
Date of Birth (mm-dd-yyyy):	Date of Injury/Onset:	Work Related: □ Yes □No	Auto Related: □ Yes □ No		
If Medicare, are you currently residing in a Skilled Nursing Facility: □ Yes □ No Name of Facility_____					
If you are Medicare, have you received Physical, Occupational, or Speech Therapy services since the beginning of the year? □ Yes □No If so, do you know if you have exceeded the Medicare cap? □ Yes □ No					
If Medicare, are you currently receiving Home Health Services: □ Yes □ No Type of service: If yes, Name of Agency:_____ Date of Last Service:					

Physician Information

Primary Care Physician (PCP):	City/State of PCP:	Physician who referred you here: City/State of Referring Physician:
May we send medical information to your PCP? □ Yes □ No		Preferred Pharmacy & City/State of Pharmacy:

Employer Information

Employer:	Employer Phone:	Employment Status: □ FT □PT □Self □ Retired □Student □None	
Address:	City:	State:	Zip:

Responsible Party (For Minors and/or Dependents for Insurance Purposes)

If Minor, Does child live with: □ Both Parents □ Mother □ Father □ Other _____		
Mother's Legal Name:	Home Phone:	Address (if different):
Date of Birth:	SSN:	Employer:
Father's Legal Name:	Home Phone:	Address (if different):
Date of Birth:	SSN:	Employer:

Emergency Contact

Contact Name:	Phone:	Relationship:

Health Care Primary Insurance

Name of Insurance:	ID #:	Group #:	Co-pay:
Policy Holder:	Date of Birth (mm-dd-yyyy):	SSN:	
Employers Name:	Relationship to patient: □ Self □ Spouse □ Dependent □ Other		

Secondary Insurance

Name of Insurance:	Policy or Claim #:	Group #:	Co-pay:
Policy Holder:	Date of Birth (mm-dd-yyyy):	SSN:	
Employers Name:	Relationship to Patient: □ Self □ Spouse □ Dependent □ Other_____		

Authorization: I, with my signature, authorize Northwest Ohio Orthopedics and Sports Medicine, Inc. (NWO) to provide medical care for me, or to this patient for which I am the legal guardian. I also authorize NWO to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes, and phone calls concerning care provided or proposed. I shall assign all payment for these services to NWO realizing I am personally responsible for the charges incurred, including items determined to be non-covered.
I authorize NWO and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.

I also acknowledge that I have been given or have been offered a copy of the "Practice's" privacy policy as required by law. I request the following restrictions be placed on the "Practice's" use and/or disclosure of my health information (leave blank of NO).

_____

_____

Patient/Guardian:_____Date:_____

Northwest Ohio Orthopedics & Sports Medicine, Inc.

FINANCIAL POLICY

Regarding Your Insurance:

Our office participates in a variety of insurance plans, and we will submit all claims to those carriers. We make every effort to get claims paid; however, please remember that your insurance policy is a contract between you, your employer, and your insurance company. Any balance remaining after the insurance has paid (i.e. co-pay, co-insurance, non-covered benefits, exclusions, etc.) **is the responsibility of the undersigned responsible party.** If NWO is not in your insurance plan, **the undersigned responsible party is responsible for all charges.** If you do not have insurance, a payment plan must be arranged, prior to treatment, with our Financial Counselor. Partial payment for self-pay patients is required at the time of the initial visit.

In an effort to minimize insurance errors and maximize insurance payment, please bring your most recent insurance card(s) with you to every visit. **Co-payments are to be paid at the time of your visit.** In the event we receive payment from your insurance company for services you have paid for, a refund will be made to you in a timely manner.

Payment Information:

We accept cash, check, and credit/debit card payments. Credit cards and/or checks can be "kept on file" for your convenience. This information is securely stored by an authorized vendor. Notification will be given before a payment transaction is performed. If you are unable to pay your balance in full, a payment plan arrangement can be made or you can sign up for CareCredit with the option of no interest financing. Contact our Financial Counselor at 419-427-3116 for more information. These options will lessen the possibility of your account being sent to a collection agency because of non-payment. A fee of $30.00 will be applied and collected from your account if payment is returned non-paid.

Past Due Accounts:

If your balance is not paid in a timely manner, we reserve the right to forward your account to an outside collection agency or attorney. A 10-day notice prior to sending your account to a collection agency will be mailed to you.

Orthopedic, Family Medicine, Chiropractic, Podiatry and Pain Management No-Show Fee:

Missed or non-cancelled appointments will result in a $25.00 no-show fee. Chiropractic appointments must be cancelled within 24 hours of scheduled appointment.

Imaging No-Show Fee:

Cancellation within 24 hours prior to a scheduled MRI or CT will be subject to a $50.00 no-show fee.

Durable Medical Equipment:

If you need to return a product, and you are the original purchaser, you need to do so within 10 days of receiving. All products must be returned in its original packaging with all instructions and parts. The product must be in new condition. We reserve the right to refuse any product not in new condition for health safety reasons. There is a 30% restocking fee on all returns. Upon notification that the product has been returned in new condition, a credit will be issued to your account less the restocking fee. For product exchanges, upon receipt of the returned product we will credit your account minus the 30% restocking fee if a product needs to be exchanged. This charge will be waived if NWO made the mistake in providing you with the wrong product.

FMLA, Disability, and Drug Company Assistance Forms:

Any patient needing forms filled out by our office will incur a onetime $15.00 fee per form. Payment for this service is due at the time of drop-off or pick-up.

Patient Name: _____

_____ _____

Signature of Responsible Party Date

Printed Name of Responsible Party: _____

Relationship to Patient (e.g., self, parent/guardian): _____

Northwest Ohio Orthopedics & Sports Medicine, Inc.

EXPLANATION OF CONDITION

Patient Name: _____
First MI Last

Date of Injury: _____/_____/_____ or have been experiencing symptoms for _____days _____ weeks _____months _____ years.

What symptoms are you experiencing? ❑Pain ❑Numbness ❑Weakness ❑Swelling ❑Stiffness ❑Other_____

What body parts are affected? _____

_____

Give a brief description of the accident. Please include location of the accident (home, work, school, auto, etc.) and a brief description (fall, bump against, collision, cut, struck by, etc.). _____

_____

_____

_____

Was this injury sustained in an automobile accident? YES NO If **yes**, please complete the following:

Will you be going through: ❑ Personal Auto Insurance ❑ Other _____

MOTOR VEHICLE ACCIDENT INFORMATION

Date of Accident: _____/_____/_____ State Accident Occurred: _____ Time: _____

Auto Insurance Name: _____ Adjuster's Name: _____

Adjuster's Phone Number: _____ Name of Insured: _____

Claim Number: _____ Policy Number: _____ MVA Work Related? Y N

We will bill your motor vehicle insurance; however, you are ultimately responsible for your account balance. We do require your health insurance information since most auto coverage is limited. We will bill your health insurance for any remaining balance after your Auto Insurance has paid. **Please note that should your motor vehicle accident require litigation proceedings, you will be required to speak with our financial counselor to arrange monthly payments in order to keep your account current during your hearings.** Once your claim has been settled, any overpayments you have made on the account will be refunded to you at that time.

NON- MEDICAL INSURANCE

Will you seek payment from another party? YES NO If yes, who? BWC MVA Home Other

If an attorney is involved, please provide name, address, and phone number: _____

_____

AUTHORIZATION

I, with my signature, authorize **Northwest Ohio Orthopedics And Sports Medicine, Inc**., and any employee working under the direction of the care provider, to provide medical care for me, or to this patient for which I am the legal guardian. I also authorize **Northwest Ohio Orthopedics And Sports Medicine, Inc**., to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes, and phone calls concerning care provided or proposed. I shall assign all payments for these services to this practice. I understand that I am responsible for all co-payments, deductible, and other amounts that may be deemed my responsibility by the insurance plan, as required by my contract with my insurance plan and state regulation.

Patient/Legal Representative: _____ Date: _____

Northwest Ohio Orthopedics & Sports Medicine, Inc.

Patient Medication List

Patient Name: _____ Date of Birth: _____

What medications do you currently take? (Including over the counter, vitamins/supplements)

☐ None

Name of Medication	Dosage	Doctor That Prescribed

Patient/Guardian Signature: _____ Date: _____

Northwest Ohio Orthopedics & Sports Medicine, Inc.

Consent for Minor to Receive Treatment

I, the parent/guardian of _____, give consent for my child to receive the following types of medical services at the Northwest Ohio Orthopedics & Sports Medicine, Inc. ("NWO"):. _____ _____ _____ that could include:

- ❑ Imaging services: CT, MRI, Ultrasound
- ❑ Chiropractic Care
- ❑ Physical/Occupational Therapy/ DME
- ❑ Pain Management

❑ **A parent will be present for all visits**

I understand that this consent form will be good until _____.

Except to the extent that the law requires my child's signed consent prior to disclosure, I understand that I will be entitled access to medical information concerning services provided to my child pursuant to this consent. I understand that nothing in this consent affects the ability of the NWO to provide medical services to my child without my consent to the extent expressly permitted under Ohio law.

I understand that I will be responsible for payment for any charges relating to services provided to my child pursuant to this consent, to the extent that such services are not covered in full by insurance or other third-party payor covering my child. NWO may release information regarding treatment to third party payers for billing purposes.

_____ _____

Signature of Parent / Legal Guardian Date

NOTARY PUBLIC SIGNATURE / STAMP / SEAL REQUIRED

State of Ohio
County of _____

Subscribed and sworn to me this _____ day of _____ 20 _____

Signature: _____
My commission expires: _____