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:

Pharmacy Information

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 one time $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): _____

1069 Klotz Road · Bowling Green, OH 43402 · Phone (419) 728-0110 · Fax (419) 728-0113
15054 E US Highway 224· Findlay, OH 45840 · Phone (419) 427-3030 · Fax (419) 427-3034

Northwest Ohio Orthopedics & Sports Medicine, Inc.

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(HIPAA Act – 45CFR Parts 160 and 164)

Name: _____ DOB: _____

Release of Information

I authorize the release of information to the following individuals (check all that apply):

❑ **Spouse:** _____
- ❑ My complete medical record
- ❑ Appointment Information
- ❑ Prescription Pick-Up

❑ **Child(ren):** _____
- ❑ My complete medical record
- ❑ Appointment Information
- ❑ Prescription Pick-Up

❑ **Other:** _____
- ❑ My complete medical record
- ❑ Appointment Information
- ❑ Prescription Pick-Up

❑ **Parent(s)** _____
- ❑ My complete medical record
- ❑ Prescription Pick-Up
- ❑ Appointment Information

❑ **Information is NOT to be released to anyone**

The ***Release of Information*** will remain effect for twelve (12) months.

Messages

Please call: ❑ my home _____ ❑ my work _____ ❑ my cell: _____

If unable to reach me: ❑ you may leave a detailed message

❑ please leave a message asking me to return your call

❑ email me: _____

This authorization shall be in force and effect until nine (9) months after my death, at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date: _____
Signature of Patient (Parent/ Guardian, if Minor)

Staff Signature/Date as Witness: _____

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: _____