Mountain Valley ORTHOPEDICS

THE STRENGTH OF EXPERIENCE

Patient Registration
Financial Policy and Privacy Statement

General Policy – As a participating provider, we will accept the carrier's allowable amount. Patients are responsible for co-payments, co-insurance amounts and/or deductibles and payment for services not covered by the carrier. Copays will be collected at each visit. If you are insured under a plan that we do not participate with and you choose to receive your care with us, we can make arrangements to bill the carrier; however, the patient is responsible for the bill in its entirety.

Please remember that your insurance plan is a contract between you and your insurance carrier. This contract usually requires a shared responsibility between the insurance and the patient for services rendered. While we will act on your behalf to obtain payment for our services, once we have exhausted all efforts, the patient is responsible for the balance due. Our office also accepts Visa, MasterCard, Discover, and American Express in addition to cash and personal checks as methods of payment. The billing department can also develop a payment plan to suit your needs to ensure that your account remains in good standing, should this become necessary. There will be a charge of $25.00 for all returned checks for insufficient funds.

Referrals – If your insurance requires a referral from your PCP for your visit, their referral must be obtained by the patient and presented at the time of the visit. If a referral is not present at the time of visit, the visit can be rescheduled to allow time to contact your PCP to obtain.

Secondary Insurances – We will submit your bill to your secondary insurance; however, failure to obtain payment within 60 days will result in the balance being billed to you. Our office will not file to tertiary insurances, but will provide you the necessary documents to do so upon request.

Self-Pay Policy – Patients without insurance coverage who wish to receive care with us must establish a payment plan with our billing department prior to receiving services or immediately after receiving emergency services.

Surgeries – When you choose to schedule a surgery with one of our doctors, we will check with your insurance carrier for any outstanding deductible amounts. If there is a deductible amount not yet satisfied for the benefit period, you will be asked to pay a portion of that deductible at the time you schedule your surgical procedure.

Collection Accounts – Our office will make every effort to communicate with you about your account and will present reasonable options for payment. In the event that we involve a third party for collection of an account, you will not be permitted to return for a new episode of care until you have satisfied the old debt.

Disability Forms – Our office will complete your disability insurance claim forms; however, it is the patient's responsibility to obtain and provide our office with the form. The fee for each form is $10 and must be paid in advance.

Authorization to Release Information – I authorize for medical information about me to be released to all providers involved in my care and to my insurance company for the purpose of processing and reimbursement of services renders. I also authorize the release of medical information pertaining to my medical care to the following individuals: _____

Medical Records – Medical records are processed through an outside medical records company, MRO. To obtain records, you must complete a medical records request forms. The form will be submitted to MRO, who will contact you regarding payment. Once payment is received, the records will be released as requested. Fees are per page. Processing time averages 5 – 7 business days; however be advised it may take up to 30 business days.

I have read the Financial Policy as outlined above.

Privacy Statement – I have received a copy of the protected health information. I give permission to Mountain Valley Orthopedics to use and disclose my health information in accordance with it.

_____ **Initials**

_____ _____/_____/_____

Patient Name **Signature** **Date**

(Office use only: ____ Refused to sign ____ Refused Copy of Privacy Notice)

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Name: _____ **Sex:** M F **DOB:** _____/_____/_____ **SSN#:** _____/_____/_____

Address: _____ **City:** _____ **State/Zip:** _____

Home Phone: ( ) _____ **Cell Phone:** ( ) _____ **Work Phone:** ( ) _____

Email: _____ **Contact Preference:** Home Cell Work

Race: ☐ African American or Black ☐ Alaska Native or American Indiana ☐ Asian ☐ Pacific Islander or Native Hawaiian ☐ White

Ethnicity: ☐ Hispanic ☐ Other ☐ Decline **Language:** _____ **Marital Status:** M S D W

How Did You Hear About Us?

☐ Advertising ☐ Family Friend ☐ Newspaper Ad ☐ Self-Referral ☐ Website

☐ Billboard ☐ Hospital Emergency Room ☐ Primary Care Physician ☐ TV Ads

☐ Community Event-Talk ☐ Insurance Company ☐ Radio Ads ☐ Specialist Physician _____

Pharmacy _____

Assignment of Benefits/Release of Billing Information

I authorize Mountain Valley Orthopedics and/or their staff to leave medical information pertaining to my care by phone, voicemail, and to contact me via email for appointment reminders and office newsletters.

I request that payment of services from Medicare/Medigap benefits be made to Mountain Valley Orthopedics, P.C. I authorize any holder of medical information about me to be released to all providers involved in my care and to my insurance company for the purpose of processing and reimbursement for services rendered. I acknowledge that I am responsible for payment of any balance not covered by my insurance company.

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

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

☐ Check here if you do not wish your medical information to be released to any individuals.

Guardian (if patient under 18): Last name: _____ First Name: _____

Emergency Contact Name: _____ **Relationship:** _____

Home phone: ( ) _____ **Mobile phone:** ( ) _____

Next of Kin Name: _____ **Relationship:** _____

Phone: ( ) _____

Employer Name: _____ **Name of Insured:** _____

DOB: _____/_____/_____ **Relation to Patient:** ☐ Self ☐ Child ☐ Spouse ☐ Other: _____

Patient Condition Related to: ☐ Employment, state _____ ☐ Auto Accident ☐ Other Accident ☐ N/A

Consent for Treatment – I hereby authorize Mountain Valley Orthopedics to provide evaluation and medical treatment necessary, including diagnostic, surgical, and/or therapy interventions, by authorized member of practice or their designee.

_____ _____/_____/_____

Patient Name **Signature** **Date**