

PAYMENT AUTHORIZATION

Thank you for choosing Mansfield Orthopaedics! In order to serve you properly, we need the following information. **Please print!** All information will be confidential.

PATIENT'S NAME _____ BIRTHDATE _____

PARENT/GUARDIAN NAME (IF MINOR) _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ HOME PHONE _____ OTHER _____

EMERGENCY CONTACT PERSON _____ PHONE _____

MALE FEMALE (CIRCLE ONE) SOCIAL SECURITY NUMBER _____

(CIRCLE APPROPRIATE STATUS) MINOR SINGLE MARRIED DIVORCED
WIDOWED SEPARATED CIVIL UNION

IS THIS A WORK RELATED INJURY? YES NO DATE OF INJURY _____

EMPLOYER NAME _____

WORKER'S COMP GROUP _____

ADDRESS _____ STATE _____ ZIP _____

CONTACT NAME _____ PHONE _____

CLAIM # _____

NAME OF PERSON RESPONSIBLE FOR ACCOUNT _____

RELATIONSHIP TO PATIENT _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

We would like to photocopy your insurance card(s) for our records. **DO NOT** complete below if we have copied your card(s).

INSURANCE COMPANY _____

NAME OF INSURED _____ RELATIONSHIP _____

CERTIFICATE NUMBER _____ GROUP NUMBER _____

Do you have any other insurance? _____ If yes, complete the following:

INSURANCE COMPANY _____

NAME OF INSURED _____ RELATIONSHIP _____

CERTIFICATE NUMBER _____ GROUP NUMBER _____

I authorize release of any information concerning my or my child's healthcare, advice and treatment for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Mansfield Orthopaedics at Copley Hospital

Signature of patient or parent (if a minor) _____ Date _____

Signature of patient or parent (if a minor) _____ Date _____

Signature of patient or parent (if a minor) _____ Date _____

PATIENT HISTORY

Name: _____ Date: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Primary Care Doctor: _____ Location: _____

Reason for today's visit: _____

Is this due to an injury? Y/N Date of injury: _____

Is this a Workman's comp claim? Y/N

Is this a motor vehicle accident? Y/N

Is this a claim in litigation? Y/N

Have you had previous testing done? (X-rays, MRI, CT scan, Ultrasound) Y/N

If so, what and where was it done? _____

Have you seen another medical provider for this problem? Y/N

If yes, Name: _____

Address: _____

Did this or another provider refer you for this visit? Y/N

If yes, Name: _____

Address: _____

Please be aware we will be sending copies of our reports to the referring provider.

If no, please identify any provider to whom we should send our reports:

Name: _____

Address: _____

Have you had any of the following symptoms?

Shortness of breath: Y/N Chest pain: Y/N

Night pain: Y/N Fevers: Y/N

What type of symptoms have you been having? _____

Does your past Orthopaedic history include the following? If so, please explain:

Broken bones or injuries: Y/N _____

Rheumatoid Arthritis: Y/N _____

Gout: Y/N _____

Bone density screen/DEXA scan: Y/N _____

Osetoarthritis: Y/N _____

Does your past medical history include the following? If so, please explain:

Asthma: Y/N _____
High blood pressure: Y/N _____
Stroke: Y/N _____
Seizures: Y/N _____
Bleeding tendency: Y/N _____
Thyroid diagnosis: Y/N _____
Depression: Y/N _____
Heart problems: Y/N _____
Diabetes: Y/N _____
History of ulcers: Y/N _____
History of cancer: Y/N _____
Other history: Y/N _____

Have you had any previous surgeries? If so, please list (include dates):

Are you taking any medication? If so, please list medications and dosage:

Do you have any allergies to medications? If so, please list:

SOCIAL HISTORY:

Marital status: Single _____ Married _____ Civil Union _____ Widowed _____ Divorced _____

Alcohol: Never ___ Rare ___ Moderate ___ Daily ___ **Tobacco:** Y/N What _____ How long _____

Are you left or right handed? _____ **What is your current working situation?** _____

What is your living situation? Alone _____ Spouse/family _____ Friends _____

Patient or guardian signature Date

Reviewed and revised patient or guardian signature Date

Reviewed and revised patient or guardian signature Date

Welcome to Mansfield Orthopaedics at Copley

Thank you for placing your trust in us to provide the best orthopedic care possible. We are your advocate working with you through the entire process including any financial and insurance issues you may have. We may not solve every problem that arises, but we will try very hard to do so.

Insurance

Insurance can be frustratingly complex, with rules that change frequently, e.g., precertifications, co-payments, denials for certain claims, etc. We want to make this as seamless as possible for you. When you arrive, please be prepared regarding the following:

- **Your insurance card:** Upon arrival in our office, we will ask to make a photocopy of your insurance card. This is so we can have a current reference for your policy numbers, group numbers, insurance company address and phone numbers, etc.
- **Is a referral required?** We are a specialty practice, and as such, many insurance plans will require that you receive a “referral” from your family doctor before they will pay for our services, sometimes including lab and x-ray procedures. Check for a number on your card for you to ask general questions. You should call this number and find out if you need a referral before your first visit with us.
- **Precertification needed?** As with referral requirements, oftentimes an insurance company will need you to call them in order to “precertify” our specialty visits or procedures. Sometimes insurance companies will pay for some things and not others. When they require precertification, they are really requiring that you check with them before committing yourself to any services. **IMPORTANT:** If you receive services (emergencies excepted) without first obtaining precertification, you risk having to pay the entire cost out of pocket.
- **Common insurance companies:** We participate with MVP, Blue Cross/Blue Shield, CBA, The Healthcare Value Management Network, North American Preferred, One Health Plan, Medicare, Medicaid, CIGNA, Champus-Tricare, to name some of the more common companies.
- **Co-Payments:** Most insurance plans require that the patient pay a certain amount of cost out of pocket and the insurance company will pay the balance. The amount that the patient pays is called the “co-pay.” It’s important for you to check your plan to see how much, if any, co-pay for which you will be responsible, just to prevent surprises at the check-out desk. Co-pays are expected to be paid at the time of service.
- **If you have no insurance:** In general, full payment is required on the day of service. We also understand that temporary financial difficulties may make full payment out of reach for you. We view our relationship with you as a partnership, of sorts, and we will always be willing to make short term payment arrangements with you during difficult times. Payments can be made with cash, personal check, VISA and Mastercard.

Your Appointment - It is very important that you keep your appointment, or if unexpected events arise that make it impossible for you to keep it, that you give us at least 24 hours notice. This is so we can bring another patient into your appointment slot. On our side of the desk, we understand that your time is valuable as well. We will always try to keep your doctor promptly on time, but it’s in the nature of medical practice that your doctor may occasionally be delayed due to reasons beyond his or her control. We ask for your patience during these times and we will try to keep you informed during the waiting period.

Again, thank you for selecting Mansfield Orthopaedics. We will always endeavor to treat you as we would like to be treated.

OFFICE POLICY AND NARCOTIC USE CONTRACT

Should you have surgery and need narcotic medications and expect this office to provide you with a prescription to help you control your pain, you **must** follow these rules for your safety. (**There will be no exceptions**):

- Narcotics will **not routinely** be given before surgery.
- Narcotic medication may be continued for a maximum duration of **8 weeks** after surgery.
- If pain continues for 8 weeks after surgery, non-narcotic medications will be used. If non-narcotic medications are not sufficient to control postoperative pain, we will work with you to find alternative methods to control pain including consultation with specialists in pain management.
- The dosage of the narcotic medication must remain the same or decrease-we will not continue to escalate the dose. If you have uncontrolled pain, we will try alternative treatments.
- We continue to be committed to helping you live comfortably. We expect you may have to learn to live with some pain.
- We must be the **only** health care provider writing prescriptions for narcotics for you.
- You must notify us of the need for a new prescription at least 48 hours before you need to pick it up and only during normal working hours.
- No prescriptions will be written on weekends or during evening hours.
- If you engage in demanding or harassing behaviors in seeking refills, we will stop renewing the prescription.
- If ever a prescription is altered we will stop the medication.
- We will not replace lost or stolen prescriptions or damaged pills.
- We will not refill a prescription before it is due to be refilled.
- Should you need to change a prescription because the medication is making you sick, you must return the appropriate amount of unused medication to the office before a new prescription can be written.
- We reserve the right to order a drug-screening test at any time. Failure to comply will result in prescription termination.

Your signature below indicates that you have read this and agree to follow the rules. We reserve the right to stop prescribing any narcotic medication should you fail to sign this contract. Should you fail to follow the rules, we will **immediately stop** prescribing **any** narcotic medications. Again, this is for your well being and safety.

PATIENT:

DATE: _____

RATIONALE FOR NARCOTIC USE

If you have been given a prescription for a pain medicine, it is intended for **short-term** use. This is a highly addictive substance and is strictly controlled by the government. **Our intention is to limit the use of this medicine to less than 8 weeks.** After 8 weeks, if you continue to have pain that is not controlled by non-narcotic medication, we will work with you to find alternative methods to control the pain.

Why limit narcotic use?

There is an extensive body of research, which suggests that, for most people, narcotic use to control chronic (longer than 8 weeks) pain is **ineffective**. Narcotic **addiction** is likely to occur when use extends beyond 8 weeks. This means that you may feel an urge to take the medication, feel sick when you miss or delay a dose, or have significant withdrawal symptoms including pain, diarrhea, headaches, and nervousness when you try to stop the medication. After 8 weeks, if you continue to have pain that is not controlled by non-narcotic medication, we will work with you to find alternative methods to control the pain.

Addictive behaviors may begin to dominate your life. You may feel intense urges to increase the dose and frequency of your narcotic medication. **Drug seeking behaviors**, including demanding extra medicine or early refills because of increased use, often show up in addicted people. The urge to increase the medicine is a result of **tolerance**, your body's adjustment to the medicine, such that higher doses are needed to achieve the same effect. Everyone on narcotics demonstrates some tolerance. Only some people demonstrate drug-seeking behaviors, and lose control of themselves such that the medicine controls their life. We want to help control your pain, but we believe that we are doing a disservice to continue prescribing narcotics beyond 8 weeks. Beyond that point you become vulnerable to tolerance and addiction.

Alternative pain control methods: Alternatives include: talk therapy to help decrease fear related to the pain, relaxation techniques, hypnosis, acupuncture, injection therapies, physical modalities such as massage, ice, heat and liniments and non-addictive medications. Alternative medicines for control of chronic pain include nerve conduction slowing medicines, antidepressant medication, arthritis pain control pills, and a few other less common options.

PAYMENT FOR SERVICES

For your convenience, all services will be processed through your insurance company if you provide the necessary billing information.

I understand that I am financially responsible for all charges whether or not paid by insurance. Some companies pay fix allowances for procedures and others pay a percentage of the charge. It is my responsibility to pay any deductible amount, co-insurance amount, or any other balance not paid for by my insurance company.

I also understand that if I have a co-payment, it is due at the time of service. If I fail to give 24 hours notice when canceling my appointment, a \$15.00 fee will be imposed. It is my understanding that I am responsible for these fees and they are not billable to my insurance company. This is necessary because other patients will not have an opportunity to be scheduled in your place when you give less than 24-hour notice to cancel.

All accounts turned over to our collection agency will be subject to interest fees and/or collection charges.

If you have indicated you have **no insurance**, please complete the following.
Otherwise please sign at the bottom of the page.

- () I would prefer to pay my account in full at this time.
- () I would prefer to pay the required amount at this time (one half of the fee charges) and be billed for the remainder. Or, I would like to make regular monthly payments of \$_____ to be started on ____/____/____ and to continue until my balance is paid in full.
- () I would prefer payment by MasterCard or Visa (circle one).
My number is _____
with an expiration date of _____.

Patient Signature _____ Date _____
(If the patient is a minor, parent or guardian must sign)