Greater Hartford Orthopedic Group

PATIENT INFORMATION FORM

(Subscriber = Insurance card holder)

Appointment Date

Answers to Questions Below ARE Required by the Federal Government American Recovery & Reinvestment Act of 2009

Social Security # | Date of Birth | Marital Status ☐S ☐M ☐D ☐W

Patient Name (First/Middle/Last) | SEX ☐Female ☐Male

Employment Status

☐Employed ☐Retired ☐Part-Time Student ☐ Full-Time Student
☐Self-Employed ☐Disabled ☐Unemployed

Race
☐Caucasian
☐Black
☐Asian
☐American Indian/Native Alaskan
☐Native Hawaiian/Pacific Islander
☐Other Race ☐Unknown

Ethnicity
☐Hispanic/Latino
☐Not Hispanic/Latino
☐Caucasian
☐Other
☐Unknown

Language
☐English
☐Spanish
☐French
☐Polish
☐Vietnamese
☐Sign
☐Other

Mailing Address | City | State | Zip Code

Email Address | Home # | Mobile # | Work # & Extension

Patient or Parent's Employer | Street Address | City | State | Zip Code | Phone #

Referred By - Name, Address & Phone # | Primary Care Physician | Address & Phone #

Primary Insurance Plan Name | Group # | Insurance ID #

Effective Date | Visit Copay $ Amount | Deductible $ Amount | Insurance Subscriber: ☐Patient ☐Parent ☐Spouse ☐Other (Explain):

Subscriber Name _____ DOB: _____ SS#: _____
Subscriber Address: Employer:

Secondary/Supplemental Insurance Plan Name | Group # | Insurance ID #

Effective Date | Visit Copay $ Amount | Deductible $ Amount | Insurance Subscriber: ☐Patient ☐Parent ☐Spouse ☐Other (Explain):

Subscriber Name _____ DOB: _____ SS#: _____
Subscriber Address: Employer:

Emergency Contact

Relationship to Patient: ☐Wife ☐Husband ☐Child ☐Parent ☐Friend ☐Guardian ☐Other _____
Name (F/M/L) | Contact Phone # | Work #

PHARMACY INFORMATION

Pharmacy Name/Address | **Phone #**

WORKER'S COMPENSATION INSURANCE INFORMATION

Date of Injury | Nature of Injury | State of Injury if not Connecticut

Work Comp Company Name & Address | Claim # | Adjuster's Name | Adjuster's Phone #

Employer | Employer's Address | Employer's Phone #

Name of Employer's Inside Contact Person | Position | Contact Phone #

AUTOMOBILE / NO-FAULT / LIABILITY / INSURANCE INFORMATION

Date of Accident | Nature of Injury | State of Injury if not Connecticut

Name of Insurance Company | Address

Name of Policy Holder | Adjuster's Name | Adjuster's Phone #

Policy # | Claim #

Attorney Name | Attorney Address | Attorney Phone #

BENEFICIARY/GUARANTOR: I request that payment of authorized insurance, Medicaid and Medicare benefits be made on my or my dependent's behalf to Greater Hartford Orthopedic Group, P.C. (GHOG) for services rendered to me by a GHOG physician. I authorize any holder of medical information about me or my dependent to release to the Centers for Medicare and Medicaid Services and its agents or my insurance company any information needed to determine benefits payable including HIV/AIDs, substance abuse, and/or mental health information for related services. I further agree to make payment for any and all services not paid for by my health insurance plan to include, but not limited to, office visit copays, x-ray copays, DME brace copays, and all deductible amounts stipulated in my contract agreement with my health insurance plan. I have been provided an opportunity to review the HIPAA Notice of Privacy Practices of Greater Hartford Orthopedic Group, P.C.

Signature **Date**

Greater Hartford Orthopedic Group

We would like to thank you for choosing Greater Hartford Orthopedic Group (GHOG) as your medical provider. To keep you informed of our current office and financial policies we ask that you read and sign our financial acknowledgement prior to any treatment.

Insurance: Please present your current insurance card to the receptionist at each visit. Your insurance carrier requires that all co-pays be paid prior to any services being rendered. We are considered a specialist office. The co-pay requirement cannot be changed, negotiated or waived by our practice, as it is required by your insurance carrier. If you do not have your co-pay at the time of your visit your appointment may be rescheduled. You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance. For your convenience we accept cash, checks and major credit cards (Visa, MasterCard, American Express and Discover).

No Insurance/Self-Pay: Payment will be due at the time of service. If you are unable to pay your balance in full you will need to make prior arrangements with our Billing Department. See Self-Pay Agreement Form for more details.

Referrals: Some insurance companies require the patient to obtain a referral for a specialist. It is the patient's responsibility to contact their Primary Care Physician for this referral. If we do not have a referral on file by the time of your appointment you may be asked to reschedule. Any services provided without a referral or proper authorization will be your responsibility and payment will be due at time of service.

Workers' Compensation: For all workers' compensation cases you must provide the following information for billing purposes at the time of scheduling your appointment; the employers name, date of injury, insurance company name and address, adjuster's name and phone number and carrier claim number. All information must be received before the date of your appointment in order for our office to verify this is an accepted workers' compensation claim and **receive** authorization to treat. We also require your private insurance information in the event that your workers' compensation claim is denied.

Motor Vehicle Accident and Personal Liability: Our office will occasionally accept patients who have been injured and expect their medical costs to be covered by their car insurance. You must provide **our** office with a letter from your insurance company stating that you have medical coverage on your policy. This is letter is also required if you do not have medical coverage as we have to submit it to your medical insurance in order to get payment for our services. We do not do third party billing. We do not accept letters of protection. We ask that bills be paid promptly even though you may be involved in a liability action against someone else.

Cancellations: If your appointment needs to be cancelled with one of our physicians, 24 hour notice must be provided; however, if this is not possible, please give as much notice as possible. Early cancellations give other patients the opportunity to utilize that available time slot. Appointments can be cancelled by calling (860) 728-6740 or (860) 253-0276. At the time of the cancellation one of our staff members can reschedule your appointment.

Delinquent Accounts: Delinquent accounts of more than 120 days without payment may be assigned to a collection agency. All collection costs will be added to your outstanding balance. Failure to pay a delinquent account could result in refusal to schedule appointments for you.

I acknowledge full financial responsibility for services rendered by Greater Hartford Orthopedic Group (GHOG). I understand that I am responsible for prompt payment of any current or past due balance including co-pays, deductibles and co-insurance amounts. I understand I am responsible for all reasonable attorney fees and collection costs in the event of default of payment of my charges, as outlined in office and financial policy guidelines.

Patient Name:_____

Patient Signature:_____ **Date:**_____