

# VSAS Orthopaedics

## Medical Information

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Type of Injury:       Auto               Work Related               Sports Injury               Other

Date of Injury \_\_\_\_\_

If injury, how did injury happen? \_\_\_\_\_

If not injury, when did symptoms appear? \_\_\_\_\_ How long have you had symptoms? \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_  Right  Left

Body part to be examined: \_\_\_\_\_ Were you x-rayed for this problem? \_\_\_\_\_

If yes, where: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

Have you ever had this same or similar condition: \_\_\_\_\_

Are you disabled?     Yes     No              Date unable to work: \_\_\_\_\_

Are you currently working?     Yes     No    If not working, date last worked: \_\_\_\_\_

Other Medical Problems: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Previous Hospitalizations/Surgeries: \_\_\_\_\_

Tobacco Use: \_\_\_\_\_ If yes, How much: \_\_\_\_\_ Drug Use: \_\_\_\_\_ If yes, How much \_\_\_\_\_

Alcohol Use: \_\_\_\_\_ If yes, How much: \_\_\_\_\_

Pharmacy Name and Phone # \_\_\_\_\_

Do you live alone? \_\_\_\_\_ Do you have to climb stairs in your home? \_\_\_\_\_ How many? \_\_\_\_\_



**PATIENT COMMUNICATION PERMISSION**

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

As a patient in our practice, from time to time we may need to communicate with you when you are not in the practice. To preserve your privacy, we would like you to indicate your preferred method for us to communicate information to you.

Without specific permission we will not release any of your medical or billing information to another person. In some cases you may wish for another person to have access to your medical information.

In the event that no one is available to answer your phone, we need your permission to leave certain types of information on your answering machine or with another person. Please indicate **your preference** by checking one or more of the boxes below.

- Do not leave medical information on an answering machine or with another person.
- I give permission for VSAS Orthopaedics personnel to leave any and all medical information pertaining to me, including appointment reminders, on my home answering machine at the number listed below:

Phone Number: \_\_\_\_\_

- I give permission for VSAS Orthopaedics personnel to give any and all medical information pertaining to me (or my child), including appointment reminders, to the individual listed below:

Name: \_\_\_\_\_

- I give my permission for VSAS Orthopaedics personnel to discuss my account balance, insurance coverage/benefits, payment plans, payments, and history of my accounts to the individual listed below:

Name: \_\_\_\_\_

**I assume responsibility to inform the practice of changes in my phone number(s), person to discuss my medical and billing information, or my preference.**

Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

## FINANCIAL POLICY

Thank you for choosing VSAS Orthopaedics. Our physicians and office staff strive to deliver the highest quality patient care.

In an effort to contain costs, both to patients and insurance carriers, VSAS Orthopaedics would like to take the time to inform you of our financial and billing policies and procedures.

### Insurance:

VSAS Orthopaedics participates with many insurance carriers. Please contact the billing office at 610-663-6945 to verify we participate with your insurance carrier.

Should our office participate with your insurance, VSAS Orthopaedics will submit all services that are covered to your insurance carrier. Our office has a contractual agreement with the insurance carrier for reimbursement from the insurance carrier. The patient may still be responsible for any deductibles, co-insurance, co-pay, or payment for services not covered under the plan.

It is important to keep the office apprised of any changes with your insurance coverage.

If you have insurance with which VSAS Orthopaedics is non-participating, any office visits are expected to be paid at the time of service. Any fracture care or procedures will be submitted to your insurance on your behalf.

### Referrals:

If you have a health insurance that requires a referral, such as an HMO or Point of Service plan, the referral must be presented at the time of service. It is the policy of VSAS Orthopaedics that the staff will not call for referrals for office services. **Failure to present this referral may result in your appointment being rescheduled.**

Our staff will obtain any necessary Pre-certification or Pre-authorization for surgery or any other procedures, and/or testing that our staff has the authorization to obtain through the managed care plan.

Co-payments are required to be paid at the time of service.

### Workers' Compensation:

If you have suffered a Workers' Compensation injury, VSAS Orthopaedics will submit claims to your Workers' Compensation carrier. The patient is responsible for having all the necessary information including but not limited to, Workers' Compensation Insurance name, address, phone number, claim number, and date of injury. Employer information is also required. Failure to supply this information will result in the patient being financially responsible for all services.

VSAS Orthopaedics will bill all work-related injuries through your Workers' Compensation carrier. If you have health insurance, this information must also be given to VSAS Orthopaedics. This insurance will only be billed should your Workers' Compensation carrier deny your claim for payment. **If your health insurance requires referrals for services please obtain all necessary referrals/authorizations for presentation at time of service. Failure to present the proper referrals may result in your appointment being rescheduled.**

If you do not have health insurance you will be required to sign a payment plan with VSAS Orthopaedics and supply your credit card information for which we may bill services which may not be paid by your Workers' Compensation carrier.

### Auto Accident Claims:

If you have suffered an injury through an Auto Accident, VSAS Orthopaedics will submit claims to your Auto Carrier. The patient is responsible to have all the necessary information including but not limited to the Auto Insurance name, address, telephone number, claim number, and the date of the accident. Failure to supply this information will result in the patient being financially responsible for all services.

VSAS Orthopaedics will bill your Auto Insurance for all services. If you have health insurance you will be required to provide your Health Insurance information to VSAS Orthopaedics. Your health insurance will only be billed should your auto benefits exhaust or be denied. **If your health insurance requires referrals please obtain these for presentation at the time of service. Failure to present the proper referrals at the time of service may result in your appointment being rescheduled.**

If you do not have health insurance you will be required to sign a payment plan with VSAS Orthopaedics and supply your credit card information for which we could bill services which may not be paid by your Auto Insurance.

**Self-Pay:**

If you do not have insurance coverage all services **must be paid at the time of service**. Should you require surgery, a portion of the surgery must be paid prior to the surgery and a payment plan can be arranged for the outstanding balance.

You will also be required to sign a payment plan with VSAS Orthopaedics and supply your credit card information for which we may bill services.

**Methods of Payment:**

Our office accepts Cash, Personal Check, Visa, MasterCard, Discover, and Check Card.

All balances are due at the time of service for those services which we will not be billing insurance carriers. All other balances are due within 30 days from the date of the statement.

All balances not paid within 30 days from the date of the statement and without a valid payment plan on file, will be considered past due and subject to a late fee of \$25.00.

Please understand if there is no payment activity within 45 days, the account will be transferred to a collection agency and subject to the collection agency fees and policy as outlined below.

The billing department makes every effort to work with our patients to assist them with payment plans for outstanding balances. The billing department will set-up a monthly payment plan utilizing your credit card for automatic monthly payments or a monthly payment plans utilizing payment by check, money order, or cash. Our minimum payment plan is \$50.00 per month.

Any checks for which we receive notification by the bank as having insufficient funds, will be charged a \$25.00 fee.

**Collection Agency:**

VSAS Orthopaedics utilizes an outside collection agency to collect on any outstanding balances which do not maintain an active/current payment status with our practice.

In the event your account is turned over to the Collection Agency, VSAS Orthopaedics will not be able to set-up payment plans with account collection balances. All collection account balances must be paid to the collection agency.

Once your account has been turned over to the Collection Agency, the patient will be responsible for all collection fees (25% will be added to your account balance) and legal fees (court costs will be added to your balance) that our office incurs through the process utilized to collect the outstanding delinquent balance.

Should your account be turned over to a collection agency **payment in full of any past due balance is expected prior to being seen in our office in the future. In addition, payment in full will be expected at the time of service for any future services.**

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY VSAS ORTHOPAEDICS -AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

\_\_\_\_\_  
Signature of Patient and/or Guardian (SEAL)

\_\_\_\_\_  
Date

**Authorization for Release of Information**

I, \_\_\_\_\_, authorize VSAS Orthopaedics  
(patient name)

to release any and all medical information pertaining to my injury

that occurred on \_\_\_\_\_ or related to a specific body  
(date)

part injured \_\_\_\_\_.

to the following parties:

Employer: \_\_\_\_\_

\*Employer includes occupational health department personnel, supervisors,  
and personnel management.

Please list any one in addition to the above separately who may receive this  
information at your place of employment:

\_\_\_\_\_  
 Disability Insurance Carrier: \_\_\_\_\_

I do not wish any information released to either my Employer or  
disability carrier.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**This authorization is valid until revoked in writing from the patient.**



*Specialty Care for All Ages*

**PATIENT ACKNOWLEDGEMENT FORM**

Our Notice of Privacy Practices provides information about how VSAS Orthopaedics (the "Practice") may use and disclose protected health information ("PHI") about you. The Notice contains a Patient Rights section describing your rights under the law. Please review our Notice thoroughly before signing this Acknowledgement form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment and health care operations. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- PHI may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has had the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their PHI but the Practice does not have to agree to those restrictions.

This Acknowledgement is signed by: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to Patient (if other than patient): \_\_\_\_\_

Name of Patient (if signed by other than patient): \_\_\_\_\_

Witnessed by: \_\_\_\_\_

(Signature of Practice Representative)

- Barry I. Berger, M.D.**  
*Pediatric Orthopaedics  
General Orthopaedics  
Trauma & Fracture Care*
- Mitchell E. Cooper, M.D.**  
*Sports Medicine  
Arthroscopic Surgery  
General Orthopaedics*
- Thomas D. DiBenedetto, M.D.**  
*General Orthopaedics*
- Amir H. Fayyazi, M.D.**  
*Orthopaedic Spine Surgeon*
- Dale J. Federico, M.D.**  
*Sports Medicine  
Arthroscopic Surgery*
- Joshua S. Krassen, D.O.**  
*Physiatry & Spine Care  
EMG/Electrodiagnosis  
Epidural Injections*
- Eric B. Lebby, M.D.**  
*Arthritic Joint Reconstruction  
Hip & Knee Replacement*
- Neal A. Stansbury, M.D.**  
*Sports Medicine  
Arthroscopic Surgery  
General Orthopaedics  
CAQ Sports Medicine*
- John J. Stapleton, D.P.M.**  
*Podiatry, Foot & Ankle Surgery*
- Prody A. Ververeli, M.D.**  
*Arthritic Joint Reconstruction  
Hip & Knee Replacement*
- Mark Walter, D.C.**  
*Certified Chiropractic Physician*
- Lawrence E. Weiss, M.D.**  
*Hand, Wrist & Elbow Surgery  
CAQ Hand Surgery*
- George A. Arangio, M.D.**  
*Emeritus*
- David B. Sussman, M.D.**  
*Emeritus*
- Andrew T. Prokurat**  
*Chief Operating Officer*
- Computerized Radiology**  
**Dexa Scan**  
**Open MRI - Whole Body**  
**Ultrasound**
- Hand Therapy**  
**Physical Therapy**
- Fracture & Sports Injury Center**  
**Joint Replacement Center**

# VSAS Orthopaedics

## Notice of Privacy Practices

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. **If you have any questions about this notice, please contact our office.**

### THIS DOCUMENT AVAILABLE IN LARGER PRINT

#### OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect.

#### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose health information that identifies you (*Health Information*). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing our practice's privacy officer.

**Treatment.** We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside of our office, who are involved in your medical care and need the information to provide you with medical care.

**Payment.** We may use and disclose Health Information so that we or others may bill and receive payment from you, insurance companies, or a third party for the treatment and services you received. For example, we may give them your health plan information so that they will pay for your treatment.

**Health Care Operations.** We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

**Appointment Reminder, Treatment Alternatives, and Health Related Benefits and Services.** We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

**Research.** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

#### SPECIAL SITUATIONS

**As Required by Law.** We will disclose Health Information when required to do so by international, federal, state, or local law.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

**Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

**Organ and Tissue Donation.** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye, or tissue donation and transplantation.

**Military and Veterans.** If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

**Workers' Compensation.** We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness.

**Public Health Risks.** We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury, or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person

who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities.** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities may include, for example: audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises; 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

**Coroners, Medical Examiners, and Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

**National Security and Intelligence Activities.** We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

**Protective Services for the President and Others.** We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

**Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary: 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; 3) for the safety and security of the correctional institution.

## YOUR RIGHTS

You have the following rights regarding Health Information we have about you:

**Right to Inspect and Copy.** You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the office's Privacy Officer.

**Right to Amend.** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the office's Privacy Officer.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the office's Privacy Officer. **We are not required to agree to your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

**Right to a Method of Communication.** You have the right to request that we communicate with you about medical matters in a certain way or a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request, in writing to the office's Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

## CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page in the top right-hand corner.

## COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the office's Privacy Officer. All complaints must be made in writing. You will not be penalized for filing a complaint.

**THIS DOCUMENT IS AVAILABLE IN LARGER PRINT.**