TIGARD ORTHOPEDIC & FRACTURE CLINIC

Date:_____

Name: _____ **Date of birth:**_____ **Age:**_____
Occupation:_____ _**Employer:**_____**Male/Female**

Full time/Part time **Length of time at employer** _____

Height:_____ **Weight**:_____ **Do you smoke?** _____ **Do you drink?** _____
Current & Past Medical Conditions:
☐ High Blood Pressure ☐ Seizure or Stroke ☐ Irregular heart beat ☐ Emphysema/Chronic Bronchitis
☐ Cancer (type)_____ ☐ Diabetes (type)_____☐ Hepatitis ☐ Hypothyroid Disorder
☐ Hyperthyroid Disorder ☐ Bleeding Disorder ☐ High Cholesterol ☐ Sleep Apnea
☐ Other: _____
_____

Current Medications:
1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Do we have permission to download your medications from your pharmacy? ☐ Yes ☐ No
Pharmacy: _____

Allergies:_____
_____

List all past surgeries and dates if known:
_____
_____

Family History: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Hypertension

Have you had any of the following?	**Yes**	**No**
Recent Weight Change? Gain or Loss		
Fatigue?		
Rash?		
Vision Changes?		
Glasses or Contacts?		
Cough?		
Wheezing?		
Asthma?		
Chest Pain?		
Palpitations?		
Constipation?		
Abdominal Pain?		
Muscle or joint pain?		
Mental status change?		
Abnormal bleeding?		
Excessive thirst or hunger?		

TIGARD ORTHOPEDIC & FRACTURE CLINIC

TOFC Financial Policy

Thank you for choosing Tigard Orthopedic & Fracture Clinic (TOFC). The following is a statement of our financial policy. All patients must accept our financial policy before receiving treatment. Full payment of your bill is considered part of your treatment. Co-pays, deductibles and co-insurance are due at the time services are rendered. We require proof of current insurance at check-in, those patients without proof of coverage may be required to pay in full or be asked to reschedule their appointments.

Accepted forms of payment: Cash, Visa, MasterCard, and Discover.

Payment Guarantee

For services rendered by Tigard Orthopedic & Fracture Clinic (TOFC), you guarantee payment of your account for any and all costs that will not be paid by an insurance carrier, government payer and any other third party payer (together referred to as "Payer"), including in the event that at a later date after the initial approval your Payer denies your claim. You further understand that any out-of-network charges may be your responsibility as determined by your Payer. You acknowledge that if your dependent is provided services, you will be responsible for payment under these same policies, terms and conditions. The "Responsible Party" listed on the Patient Data Sheet will be sent the statement and shall be responsible for the balance due. If the Responsible Party is not you and that person does not pay the bill, YOU are responsible for satisfying the Statement.

Regarding Your Insurance

As a courtesy to you, we will submit medical claims to your insurance company. Any balance after processing of our claim by your carrier is your responsibility. We extend this courtesy to any secondary insurance which is not on file at the time of your visit. Billing an additional insurance not on file at the time of service is the patient's responsibility. The request to re-bill or bill alternate insurances will result in additional administrative fees. Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in-network with your insurance company. Billing your insurance does not necessarily ensure payment by the insurance company, nor does it release the responsible party from its financial obligation to our office for any unpaid balance. In case of an insurance partial payment, the balance is due by YOU and we will send you a billing statement. Balances over 120 DAYS past due may be sent to a collection agency, unless other arrangements have been made. Should you require a payment plan, our office manager will be glad to discuss your options with you. It is your responsibility to know your insurance benefits as it may not cover all the services provided to you. These bills are non-negotiable.

Regarding Work-Related Injuries

We will file Workers' Compensation claims with your employers' workers' compensation insurance carrier.

Motor Vehicle Accidents (MVAs) and Third-Party Insurance Policies

TFC will bill your motor vehicle insurance. You are required to provide your private/commercial health insurance information. This will be billed should your MVA (PIP) coverage become exhausted.

TIGARD ORTHOPEDIC & FRACTURE CLINIC

Completion of Forms

You will be charged a fee of $25.00 for the completion of forms such as AFLAC, FMLA, ect. You may also be required to schedule an appointment for form completion. Payment is due at the time that you pick up these forms. Please allow 7 – 10 business days for the completion of these forms.

There is an additional charge of $75.00 for same day service for the completion of the outside medical forms.

Fees

A $35.00 service fee will be charged for all checks returned to our office due to insufficient funds. If your check is returned, you will be required to pre-pay in full for any additional services by cash or credit card.

An administrative fee of $25.00 per month may be charged for all past due balances over 30 days.

A $50.00 fee may be assessed on accounts placed in collections.

Overdue and Collection Accounts

Patients with past due accounts will be asked to make payment in full before being seen at TOFC. We reserve the right to forward your account to a collection agency if it is determined to be uncollectable. If your account is referred to an outside collection agency, you will be required to pay any unpaid balance before any further appointments can be scheduled. If your account has been sent to collection or you file bankruptcy, any future appointments will require cash payment in advance for any services rendered.

Accepted Insurance Policies

For current health insurance information, please call your health insurance administrator to verify provider enrollment with the physicians of Tigard Orthopedic & Fracture Clinic. With constant changes in health insurance coverage, as well as plans merging and restructuring, we may not be enrolled as providers with your plan.

We emphasize that as providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the DATE SERVICES ARE RENDERED. Therefore, it is necessary for you to know what benefits your insurance plan provides for you.

We may also elect to discharge you from our practice should you fail to comply with our policies.

I have read and understand the office financial policy and agree to comply. I accept the responsibility for any payment that becomes due as outlined previously.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Responsible parties Name	Responsible parties' signature	Relationship

(Rev. 1/2020)

TIGARD ORTHOPEDIC & FRACTURE CLINIC

A **NOTICE OF PRIVACY PRACTICES** is provided to all patients on their first visit. This Notice of Privacy Practices identifies how medical information about you may be used or disclosed. It explains your rights to access your medical information. How to request an accounting of disclosures of your medical information and to request additional restrictions on our use and disclosures of that information. It explains your options if you believe your rights have been violated, our responsibilities for maintaining the privacy of your medical information and letting you know if that privacy has been breached.

The undersigned has received a copy of the NOTICE OF PRIVACY PRACTICES and is the patient or the patients' personal-representative.

Name of Patient and/or Personal Representative (if applicable)

Signature

Date

(Rev. 01/2020)

TIGARD ORTHOPEDIC & FRACTURE CLINIC

Assignment of Benefits Form

Name of Insured (print):_____

Social Security Number:_____

I request that payment of authorized insurance benefits be made on my behalf to the organization listed below for any equipment or services provided to me. This includes Medicare, if you are a Medicare beneficiary.
I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other entity if requested. The original authorization will be kept on file by TOFC.
I understand that I am financially responsible to the organization for any charges not covered by my health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment and products received.

ORGANIZATION

Tigard Orthopedic & Fracture Clinic
9445 SW Locust Street
Tigard OR, 97223

Name of person signing below (print):

_____

Relationship to Insured: _____

Signature of Insured or Parent/Guardian:

_____

Date: _____

For questions regarding this or any of the forms or for general questions, please call 503-352-1313.

(Rev. 01/2020)

TIGARD ORTHOPEDIC & FRACTURE CLINIC

General Consent to Treatment and Right to Refuse Treatment

General consent to treatment: By signing below, I (or my authorized representative on my behalf), authorize Tigard Orthopedic & Fracture Clinic and their Staff to conduct any diagnosis examinations, tests and procedures. Also, to prescribe any medications, treatment or therapy necessary to effectively assess, maintain my health, to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure. My treating health care provider will also explain the available treatment options and the common risks, anticipated burdens and benefits associated with these options, as well as, alternative courses of treatments available.

I understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment. I also understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers.

Patient Name: _____ Date of birth:_____

Authorization to Release Information & Pharmacy

I hereby authorize any physician, hospital, pharmacy, or medical care facility to provide all information regarding my medical or pharmaceutical history and treatment to Tigard Orthopedic & Fracture Clinic. I furthermore will allow my pharmacy to supply verification of benefits. I also authorize Tigard Orthopedic & Fracture Clinic to release my medical information to other physicians as needed to facilitate treatment.

Preferred Pharmacy: _____ City:_____

Signature:_____ Date:_____