Denali Orthopedic Surgery, P.C.
Patient Registration

Patient Information

Name: _____
First MI Last

Mailing Address:_____City:_____State:_____Zip:_____

Primary Phone:_____ Secondary Phone:_____

Social Security Number: _____ Date of Birth:_____

Gender: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Email Address:_____

Federal Legislation requires providers ask each patient for the following information. These categories and selection choices were determined by Federal Legislation. Please complete these areas below.

Please indicate by circling one that applies to you in **each of the three categories listed.**

Ethnicity

☐ Decline
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Language

☐ English
☐ Spanish
☐ Other

Race

☐ Decline
☐ American Indian/Alaska Native
☐ Asian
☐ Black/African American
☐ Native Hawaii/Other Pacific Islander
☐ White

Employer Information

Employer:_____ Occupation:_____ Phone:_____

Mailing Address:_____City:_____State:_____Zip:_____

Emergency Contact Information

Name:_____ Phone/Cell:_____ Relationship:_____

Minor Patients (Under Age 18) We WILL NOT bill anyone who is absent at the time of service.

The parent or guardian accompanying the minor to the office is responsible for any charges incurred and any payments due at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless prior arrangements for treatment have been made. In the case of multiple guardians (divorce or separation), the financial responsibility becomes that of the guardian who accompanies the patient to their appointment. If insurance coverage is under a guardian not present at the time of service, the information pertaining to that coverage (address, SSN, ID#, and group number) is required to bill the insurance.

Parent or Guardian Name:_____ Relationship:_____

Address (if different than above): _____ City:_____ State:_____ Zip:_____

Home Phone (if different from above):_____ Cell Phone:_____

Social Security Number:_____ Date of Birth:_____

Employer:_____ Employer Phone:_____

Other Parent of Guardian Name:_____ Relationship:_____

Address (if different than above): _____ City:_____ State:_____ Zip:_____

Home Phone (if different from above):_____ Cell Phone:_____

Social Security Number:_____ Date of Birth:_____

Employer:_____ Employer Phone:_____

Insurance/Billing Information

Will this visit be covered under Workers Compensation or Motor Vehicle/Liability Insurance? ☐ Yes ☐ No

Do you have insurance? ☐ Yes ☐ No

If YES, please complete insurance information below:

Primary Insurance Company:_____ID#:_____Group#:_____
Insured Name:_____SSN:_____DOB:_____
Relationship to Patient:_____Employer:_____
Insurance Address:_____ City:_____ State:_____ Zip:_____
Insurance Phone Number:_____

Secondary Insurance Company:_____ ID#_____ Group#:_____
Insured Name:_____SSN:_____DOB:_____
Relationship to Patient:_____Employer:_____
Insurance Address:_____ City:_____ State:_____ Zip:_____
Insurance Phone Number:_____

Authorizations (**HIPAA law makes it illegal for information to be released without the Patient's written authorization.**)

I authorize Denali Orthopedic Surgery, P.C. to **discuss billing/medical information** with the individual below:

Name:_____ Relationship to Patient:_____

I authorize the below individual to **be present in the exam room** while I am being treated and care is discussed:

Name:_____ Relationship to Patient:_____

I authorize Denali Orthopedic Surgery, P.C. to release medical information to my child's school nurse at:

_____
Name of School (Minors Only)

_____ _____
Signature **Date**

If signed by someone other than the patient, please state relationship:_____

Notice of Billing / Collection Policy / Consent for Treatment / Privacy Practices

I have been provided a copy of Denali Orthopedic Surgery's financial policy which outlines their billing/collection procedures. I authorize all proceeds from insurance to be assigned to this office where applicable. I confirm that the information I have provided is true to the best of my knowledge. Additionally, I authorize treatment of the named patient contained in this registration packet.

With my consent, Denali Orthopedic Surgery, P.C. may share my health information for treatment, billing, and healthcare operations. I have been given a copy of the practice's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Denali Orthopedic Surgery, P.C. has the right to change this notice at any time. I may obtain a current copy by contacting the office, or the Privacy Officer/Practice Manager. I may revoke my consent in writing except to the extent Denali Orthopedic Surgery has already made disclosures relying upon my prior consent.

_____ _____
Signature **Date**
If signed by someone other than the patient, please state relationship:_____

Denali Orthopedic Surgery, P.C.
Financial Policy

The following information outlines financial responsibilities related to payment for professional services provided by our physicians and staff. If you have any questions or concerns, please do not hesitate to ask a member of our staff for clarification. We believe a clear understanding of our financial policy is essential to our professional relationship. Additionally, your commitment to your account is just as significant as your participation with your health care.

Please be informed Denali Orthopedic Surgery, P.C. reserves the right to refuse treatment to patients who are non-compliant with payment of their debt to our office. Please do not allow your account to become delinquent, as this will jeopardize your current and future patient/physician relationship with our office.

Financial Responsibility

Denali Orthopedic Surgery, P.C. requires a copy of any insurance information and photo identification prior to treatment. You, the patient or guardian, are ultimately responsible for all charges associated with your care regardless of insurance coverage. If you have insurance, please remember your insurance policy is a contract between you and your insurance company and that you have final responsibility for payment of your bill. Limiting language on your proof of insurance card or on the payment check from your insurer does not relieve you from responsibility for payment, unless Denali Orthopedic Surgery has expressly agreed in writing. For your convenience our office accepts cash, check, Visa, MasterCard, Discover, American Express, and Care Credit.

Self Pay

If you do not have insurance, payment in full is expected at the time of service. If you are unable to pay in full at the time of service, arrangements will need to be made with our staff prior to treatment.

Contracted Insurance

Denali Orthopedic Surgery, P.C. is only contracted with the Blue Cross/Blue Shield, CIGNA and EBMS. Payment of any unmet deductible, coinsurance and/ or copay is due at the time of service. You will receive a bill for any further portions due after your carrier processes your claim.

Non-Contracted Insurance

Denali Orthopedic Surgery, P.C. is non-contracted with all insurance plans, except BlueCross/Blue Shield, CIGNA and EBMS. As a courtesy, we will bill most insurance companies. Payment of any unmet deductible, coinsurance and/or copay is due at the time of service. You will receive a bill for any further portions due after your carrier processes your claim. Please be aware your insurance company may not cover all the services provided. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any arbitrary determination of “usual and customary” rates by your insurance carrier, or any attempt by them to limit the amounts owed by placing language on your proof of insurance card, or on the payment checks.

Denali Orthopedic Surgery, P.C.
Financial Policy (Continued)

Medicare
Denali Orthopedic Surgery P.C. participates in the Medicare program; therefore, we will bill Medicare and accept assignment of benefits. If you have a secondary insurance plan, we will not require copayment at the time of service. However, if you only have Medicare we will collect 20% of the Medicare allowable at the time of service. Please be aware some services are not covered by Medicare and are the patient's responsibility. You will receive a bill for any further portions due after Medicare processes your claim.

Medicaid
Denali Orthopedic Surgery, P.C. currently accepts Medicaid as a form of insurance on a case-by-case basis. We require a Medicaid card or other proof of eligibility at the time of service. If you are 18 or older- $3.00 copay will be collected at each visit, unless otherwise instructed by Medicaid. If you are currently applying for Medicaid or do not show proof of eligibility, you are responsible for payment of your visit at the time of service.

Workers' Compensation
In the event that your treatment may be due to a workers' compensation injury, we will need a supplemental workers' compensation form completed. We will need information such as your employer, insurance carrier, adjuster's name and phone number, claim number, as well as reports specific to your injury. If all the necessary information is given at the time of service, no payment will be collected from you. Our office does not accept out of state or Federal Workers' Compensation claims.

Motor Vehicle/Liability
If you are injured in a motor vehicle accident or are covered by a liability insurance company, you will need to supply us with the insurance company name, billing address, adjuster information, and claim number. We will contact the insurance company to confirm there is an open claim with Med Pay. Our office only accepts motor vehicle/liability insurance if you have medical payments coverage available.

Motor Vehicle/Liability(Cont'd)
However, if we are unable to verify medical payment coverage of your medical bills, we will collect in-full at the time of service. If your insurance plan involves payment of medical bills upon settlement only, we will require payment in full at each visit. We do not bill third party coverage.

Tricare
We are an authorized Tricare provider; however, **you must** have an authorization from Tricare **prior** to treatment in our clinic. By signing the patient registration form, you acknowledge you received a copy of our financial policy and agree that you are solely responsible for your bill at this office if treatment was **not** pre-authorized. This statement does not include Tricare for Life, as this a Medicare program.

VA Choice
We are a VA Choice (VCP) provider; however, **prior authorization** is required for treatment. If treatment was not pre-authorized, you are responsible for your bill at the time of service.

Denali Orthopedic Surgery, P.C.
Financial Policy

Finance Charges/ Collection Fees

Denali Orthopedic Surgery, P.C. assesses finance charges on any account balance not paid within 90 days from the date of service. The finance charge will be computed at the rate of .875% per month or an annual percentage rate of 10.5%. The minimum finance charge is $1.00. Any expense incurred collecting delinquent accounts is added to the account balance. This includes, but is not limited to, the collection fee charged by the collection agency.

Patient Name: Date of Birth:

Signature: Date: