TRI-CITY ORTHOPAEDICS

PATIENT NAME:

(Last) _____ (First) _____ (Middle) _____

□Female □Male Birth Date: _____ Age: _____ Social Security No: _____

□Single □Married □Widowed □Divorced

Mailing Address: _____

(City) _____ (State) _____ (Zip) _____

Phone: Home: _____ Cell: _____ Work: _____

Preferred Phone: _____ Email: _____

*****By signing this document, I am giving Tri City Orthopaedic Clinic permission to contact me on all phone numbers listed and/or leave voice message if necessary with pertinent patient information.**

Ethnicity: □Caucasian □Hispanic/Latino □Asian □American Indian/Alaskan Native □Black/African American □Native Hawaiian/Other Pacific Islander □Decline

Language: □English □Spanish □Russian □Other Interpreter Service: _____

□Employed □Unemployed □Full Time Student □Retired □ Disabled

Employer: _____ Phone: _____

Referring Source (i.e. Doctor, TV, Newspaper, Friend): _____

Reason For Visit (List Body Part): □Left_____ □Right_____

Person Responsible For Payment: (if patient is a minor under 18):

(Last) _____ (First) _____ (Middle) _____

□Female □Male Birth Date: _____ Age: _____ Social Security No: _____

Mailing Address: _____

(City) _____ (State) _____ (Zip) _____

Phone: Home: _____ Cell: _____ Work: _____

Employer: _____

IS THIS PROBLEM WORK RELATED? □Yes □No Employer at the time of injury: _____

Injury Date: _____Claim Number: _____ Claim Manager: _____

Last date worked: _____

Industrial Insurance Carrier: _____

Insurance Carrier Address: _____

(City) _____ (State) _____ (Zip) _____ Phone: _____

Is the Claim Currently Open: □Yes □No If Not, When Did the Claim Close? _____

IS THIS PROBLEM THE RESULT OF A MOTOR VEHICLE ACCIDENT? □Yes □No

Date of Accident: _____ State Accident Occurred: _____

Claim Number: _____ Claim Manager: _____ Phone: _____

MVA Insurance: _____

MVA Insurance Address: _____

(City) _____ (State) _____ (Zip) _____ Phone: _____

OVER

Primary Medical Insurance:_____ Effective Date: _____
Subscriber ID #:_____
Group #:_____ Copay:_____
Subscriber Name: _____
Subscriber Birth Date: _____ Social Security No: _____ □Female □Male
Subscriber Address: Mailing Address: _____
(City) _____ (State) _____(Zip) _____
Phone: Home: _____ Cell: _____ Work: _____
Subscriber Employer: _____

Secondary Medical Insurance: _____ Effective Date: _____
Subscriber ID #:_____
Group #:_____ Copay:_____
Subscriber Name: _____
Subscriber Birth Date: _____ Social Security No: _____ □Female □Male
Subscriber Address: Mailing Address: _____
(City) _____ (State) _____ (Zip) _____
Phone: Home: _____ Cell: _____ Work: _____
Subscriber Employer: _____

Tertiary Medical Insurance: _____ Effective Date: _____
Subscriber ID #:_____
Group #:_____ Copay:_____
Subscriber Name: _____
Subscriber Birth Date: _____ Social Security No: _____ □Female □Male
Subscriber Address: Mailing Address: _____
(City) _____ (State) _____(Zip) _____
Phone: Home: _____ Cell: _____ Work: _____
Subscriber Employer: _____

Emergency Contact:
(Last) _____ (First) _____ (Middle) _____
Phone: Home: _____ Cell: _____ Work: _____
Relationship to Patient: _____ Birth Date: _____

I have completed the above information to the best of my knowledge. I request that payment of authorized benefits be made to me or on my behalf to Tri City Orthopaedic Clinic for any services furnished to me. I authorize Tri City Orthopaedic Clinic to release any medical information which may be requested to determine benefits through my above named insurance carrier. I understand that if any insurance does not pay in full for services provided by Tri City Orthopaedic Clinic, I assume liability for the unpaid portion. This agreement shall be governed and enforced in accordance with the laws of the State of Washington.

X_____

Signature of Authorized Person Date Relation

Created: 4/5/2012
Edited: 12/5/13

TRI-CITY ORTHOPAEDICS

6703 W. Rio Grande Ave.
Kennewick, WA. 99336
Ph: (509) 460-5588
Fax: (509) 783-5438

821 Swift Blvd.
Richland, WA. 99352
Ph: (509) 460-5588
Fax: (509) 946-7253

965 Goethals Dr.
Richland, WA. 99352
Ph: (509) 460-5588
Fax: (509) 943-9521

Please list your current medications, including any over the counter medications (herbs/vitamins):

Patient Name: _____ DOB: _____

Primary Care Physician:_____ Referring Physician:_____

Pharmacy of Choice: _____ Occupation:_____

Today's Date: _____

Name: _____ Dose: _____ How often: _____

Name: _____ Dose: _____ How often: _____

Name: _____ Dose: _____ How often: _____

Name: _____ Dose: _____ How often: _____

Name: _____ Dose: _____ How often: _____

Name: _____ Dose: _____ How often: _____

Name: _____ Dose: _____ How often: _____

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Office Policies for Tri-City Orthopaedic Clinic

Patient Information:
You are required to provide photo identification at each visit along with any current insurance information. Please notify the receptionist when you have any changes to the following: Address, phone (work, cell or home), insurance.

Co-pays/Deductibles/Co-insurances:
If your insurance requires any of the above, you will be asked to pay this at the time of service. For your convenience we accept cash, check, debit/credit cards (Visa, MasterCard, Discover and American Express). If you are unable to pay these at time of service you agree to a $20 fee to be added to your bill.

Prior Balances:
Prior balances must be paid within 30 days unless a signed payment plan has been executed.

Self Pay:
We ask that payment be made in full at the time of service unless prior arrangements have been made with the Patient Account Representative. We accept cash, debit and/or credit cards (Visa, MasterCard, Discover and American Express). If we are an out of network provider with your insurance company and you do not have out of network benefits, then you will be considered a cash pay patient and agree to the cash pay policy above.

Reminder Calls:
As a courtesy you will receive an automated reminder call for your scheduled appointment. We ask if you are unable to make this appointment to notify us as soon as possible. ***Ultimately it is your responsibility to remember your appointment time and date.***

Cancelled or Missed Appointments:
We will do everything possible to make sure that your appointment is on schedule. Patients arriving more than 15 minutes late may not be seen. New patients who do not arrive early enough to complete paperwork before their appointment may need to be rescheduled.

No Shows:
If you are unable to show up for a scheduled appointment we require a phone call 24 hours (not including weekends) in advance. If an emergency arises and you need to call and cancel an appointment with less than 24 hours notice, please let the receptionist know the reason for your cancellation. If this is not done the cancellation may be designated as a “No Show”. After three (3) “No Show” appointments, TCO may discharge you from the clinic.

Insurance:
Many people are under the impression that if they have insurance, it is the insurance company that owes TCO for your services. This is NOT the case. TCO bills your insurance as a courtesy. The insurance contract is between you and the insurance company. If your insurance does not pay TCO please contact the billing department to make payment arrangements.

Revised: 03/24/2014
Created: 03/19/2013

Workman's Compensations/Motor Vehicle Accidents:
All information has to be provided prior to scheduling the appointment in order to verify claim is open and allowed or that Personal Injury Protection is not exhausted or your appointment may be rescheduled. If no private insurance is available and we are unable to verify an open claim, there is a mandatory $150.00 deposit required at time of service in the form of cash/check/credit/debit/money order. Once we verify a claim is open and allowed, we will refund any money owing on the claim (refer to Refund policy).

Prescription Refills:
We require 24-48 hours notice on all refills. Refill requests accepted during office hours only, as posted, or online via our website. Any prescription refill requests need to go thru your pharmacy. Request a fax to be sent to our office for the refill. Due to our surgery schedules, the physicians are not always available to sign medication requests.

Forms and/or Paperwork Fee:
There is a $15.00 fee for the completion of a form or paperwork. We require 7-10 working business days to complete both.

Bankruptcy:
If you have previously declared bankruptcy within our clinic, you will be required to sign a Bankruptcy Contract. There is a $75.00 deposit prior to each visit in the form of cash/credit/debit/money order. After each visit, your patient responsibility will be calculated and the deposit will be applied, any additional amount owing will be collected at this time. Any refund will be processed at this time. As a courtesy we will bill your insurance.

Collection:
If you have previously been sent to collections, you will be required to sign a Collection Contract. There is a $75.00 deposit prior to each visit in the form of cash/credit/debit/money order. After each visit, your patient responsibility will be calculated and the deposit will be applied, any additional amount owing will be collected at this time. Any refund will be processed at this time. As a courtesy we will bill your insurance.

Refund:
If you feel you have a credit on your account, please contact the Billing Department. If all your care is completed and all services have been paid a refund will be issued within two (2) weeks after an account audit has been conducted. Even if no request has been made account audits are regularly conducted and any refund owing will be issued once audit is completed.

I have read and agree to the above. Further, I agree that if I fail to abide by these policies I may be discharged from the clinic.

_____ _____

Patient Name (Print) Date of Birth

_____ _____

Patient Signature/Signature of Authorized Person Date

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Richland, WA 99352
Ph: 509-460-5588
Fax: 509-943-9521

HIPAA Consent Form

Patient's Full Name _____ **Patient's Medical Record Number** _____

Address _____ **Patient's Date of Birth** _____

City, State Zip Code _____ **Patient's Telephone Number** _____

I hereby authorize **VERBAL** use or disclosure of protected health information about me as described below. This consent does not serve as a release of medical records. Any medical records requests will need to be submitted in writing.

The following may receive disclosure of protected health information about me:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

YES, DISCLOSE THIS INFORMATION *_____

NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying TCO in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires one year from date of signing.

_____	_____	_____
Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth**

OR, if applicable –

_____	_____	_____
Signature of Guardian or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

TCO-Patient Email Communication Consent Form

Risks Of Using Email: TCO offers patients the opportunity to communicate by email. Transmitting patient information poses several risks of which the patient should be aware. The patient should not agree to communicate with TCO via email without understanding and accepting these risks. The risks include, but are not limited to, the following:

- The privacy and security of email communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and keep emails that pass through their system.
- Email is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent.
- Emails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
- Email can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of TCO or the patient. Email senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients.
- Email is indelible. Even after the sender and recipient have deleted their copies of the email, back-up copies may exist on a computer or in cyberspace.
- Use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Email can be used as evidence in court.

Conditions Of Using Email - TCO will use reasonable means to protect the security and confidentially of email information sent and received. However, because of the risks outlined above, TCO cannot guarantee the security and confidentiality of email communication. Thus, patients must consent to the use of email including agreement with the following conditions:

- Emails to or from the patient concerning diagnosis or treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails.
- Although TCO will endeavor to read the respond promptly to an email from the patient, TCO cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus, the patient should not use email for medical emergencies of other time-sensitive matters.
- The patient should not use email for communication regarding sensitive medication information, such as sexually transmitted disease, AIDS/HIV, mental health, developmental disability, or substance abuse. Similarly, TCO will not discuss such matters over email.
- TCO is not responsible for information loss due to technical failures associated with the patient's email software or internet service provider.

Instructions For Communication By Email - To communicate by email, the patient shall:

- Limit or avoid using an employer's or other third parties computer.
- Inform TCO of any changes in the patient's email address.
- Take precautions to preserve the confidentiality of emails, such as using screen savers and safeguarding computer passwords.
- Withdraw consent only by e-mail or written communication to TCO.

Patient Acknowledgement And Agreement - I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between TCO and me, and consent to the conditions outlined herein, as well as any other instructions that TCO may impose to communicate with patients by email. I acknowledge TCO's right to, upon the provision of written notice; withdraw the option of communicating through email. Any questions I may have had were answered.

Patient Name: _____

Legibly Printed Patient Email Address: _____

Patient Signature: _____ Date: _____