BONE & JOINT SPECIALISTS OF WINCHESTER, P.C.

REGISTRATION FORM

~ Please Print Legibly and Complete All Information ~

PATIENT INFORMATION

DATE: ______________________ CHART #: ______________________

VERIFY: ______________________ EMAIL ADDRESS: ______________________

PATIENT NAME: ______________________
First Middle Last Maiden

DATE OF BIRTH: ______________________ AGE: ______________________ SEX: ○ MALE ○ FEMALE

ADDRESS: ______________________ HOME PHONE: ______________________

CITY: ______________________ STATE: __________ ZIP: __________ WORK PHONE: ______________________

PATIENT'S SOCIAL SECURITY #: ______________________ CELL PHONE: ______________________

PATIENT'S EMPLOYER: ______________________ EMER. PHONE: ______________________

EMPLOYER ADDRESS: ______________________ OCCUPATION: ______________________

PATIENT'S MARITAL STATUS: ○ Single ○ Married ○ Divorced ○ Widowed SPOUSE'S NAME: ______________________

REFERRING PHYSICIAN: ______________________
Name Address

GUARDIAN NAME: ______________________ SS#: ______________________

GUARDIAN ADDRESS: ______________________

GUARDIAN EMPLOYER: ______________________
Name Address

INSURANCE INFORMATION

PRIMARY INSURANCE CO: ______________________

NAME OF POLICYHOLDER: ______________________ DATE OF BIRTH: ______________________

RELATIONSHIP OF PATIENT TO POLICYHOLDER: SS#: ______________________

○ Self ○ Husband ○ Wife ○ Child ○ Parent ○ Other CO-PAY: ______________________

SECONDARY INSURANCE CO: ______________________

NAME OF POLICYHOLDER: ______________________ DATE OF BIRTH: ______________________

RELATIONSHIP OF PATIENT TO POLICYHOLDER: SS#: ______________________

○ Self ○ Husband ○ Wife ○ Child ○ Parent ○ Other CO-PAY: ______________________

THIRD INSURANCE CO: ______________________

NAME OF POLICYHOLDER: ______________________ DATE OF BIRTH: ______________________

RELATIONSHIP OF PATIENT TO POLICYHOLDER: SS#: ______________________

○ Self ○ Husband ○ Wife ○ Child ○ Parent ○ Other CO-PAY: ______________________

PHARMACY: ______________________

PAYMENT GUARANTY AGREEMENT
ASSIGNMENT OF INSURANCE BENEFITS
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In consideration of service rendered to the patient named hereon for this treatment, the undersigned jointly and severally guarantee payment to Bone and Joint Specialists of Winchester, P.C., of all charges incurred on behalf of said patient.

It is understood and agreed upon between BJSW and the undersigned that:

1. Upon demand by BJSW, the undersigned agrees to pay the entire balance due;

2. The undersigned hereby assigns to BJSW with regard to its charges, any and all right and benefits the undersigned may have under any policy of insurance (hospitalization, major medical, automobile, worker's compensation or any other) and hereby authorizes BJSW and its agents of release whatever medical information necessary to perfect a claim under such policy. Any such billings made directly to such insurance company in no way relieves the undersigned of obligations as stated in this agreement, and I further understand that any pre-admission approval requirements of any policy of insurance are my responsibility, and that I must pay portions of my bill which are not paid by insurance;

3. Finance charge (no charge if paid in 30 days of billing date) is computed by a "Periodic Rate" of 1.5% per month, which is an ANNUAL PERCENTAGE RATE (APR) or 18% applied to the previous balance without deducting current payment and/or credits appearing on any given charge. Upon default in the payment of the balance owed, the above rate will be charged on the unpaid balance at 1.5% per month until the delinquency is paid. Guarantor(s) further agree to pay any/all collection fees incurred and legal expenses, including but not limited to Collection Agency fees and attorney fees at 33.3%, all court related costs, service and filing fees, interrogatory and garnishment fees as well as any interest that may be adjudicated for the collection of past due debt on accounts with this provider.

4. BJSW may make a payment agreement with any or all the undersigned, or any other person liable for the payment of the bill, which agreement shall be considered ancillary to and not in lieu of this agreement. Such payment agreement shall not be construed as limiting or modifying the liability of any person liable for charges and shall not be construed as in any way limiting the right to continue collection action against any person liable for charges hereby;

5. With this consent, Bone & Joint Specialists or Winchester, P.C., and its agents may call my home, my cell phone, or my designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare options, such as appointment reminders, insurance and billing items and any call pertaining to my clinical care, including laboratory results among others.

6. The undersigned hereby states that for the purposes of the assignments and authorizations contained herein, a photocopy of the original executed document shall be as valid as the original and any and all persons affected by the assignment and/or requesting an authorization are hereby directed to honor said copy.

I HAVE EITHER READ OR HAD FULLY EXPLAINED TO ME THIS DOCUMENT.

____ ____________________

Patient/Guarantor Signature Date

CONCERNING MEDICARE

I hereby authorize Bone & Joint Specialistsof Winchester, P.C. to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including material information for this or any related claim, to my insurance carrier; or, in the case of Medicare Part B benefits to the Social Security Administration and Health Care Financing Administration. I further authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Bone & Joint Specialists of Winchester, P.C. for services rendered. A copy of the Authorization may be used in place of the original.

THIS AUTHORIZATION MAY BE CANCELED AT THE REQUEST OF THE PATIENT.

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Lifetime Signature of Patient, Insured or Beneficiary Date

NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING

A law was enacted in Virginia in 1989 which authorizes healthcare providers to test their patients for HIV antibodies when the healthcare provider is exposed to body fluids of a patient in a manner which may transmit Human Immunodeficiency Virus (HIV). Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the healthcare provider who may have been exposed. However, you would be informed before any of your blood would be tested for HIV antibodies. Pursuant to this provision, the testing would be explained and you would be given the opportunity to ask any questions you might have.

I HAVE READ AND UNDERSTAND THE ABOVE "NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING".

____ ____________________

Patient Signature Date

ACKNOWLEDGMENT
OF
RECEIPT
OF
PRIVACY POLICY

I hereby acknowledge that I have read the Bone & Joint Specialists of Winchester, P.C. Privacy Brochure located here: www.BoneAndJointSpecialists.com/about/privacy-policy

____

Patient Name

____

Patient or Legal Representative Signature

____

Date

Information may be released to:

NAME: ______________________________ RELATIONSHIP: ____________________

NAME: ______________________________ RELATIONSHIP: ____________________

NAME: ______________________________ RELATIONSHIP: ____________________