Bethesda–Chevy Chase Orthopaedic Associates, L.L.P.
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Practice Administrator

Telephone (301) 530-1010
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To our Patients:

Welcome to the practice. We anticipate you may have many questions about your medical condition, what to expect from your visits with us and how we will work with you and your other healthcare providers. It is our belief that by working together we may achieve the best possible outcome for you. We are happy to assist you to ensure you receive the most comprehensive, up-to-date treatment in an environment that fosters understanding, compassion, consideration and respectful care.

We feel that open and effective communication is essential in helping you achieve your health-related goals. Accordingly, we have prepared the attached brochure and patient registration documents to assist you in understanding how our practice works and how you may best work with us. We encourage you to familiarize yourselves with these materials. Please feel free to seek assistance from our staff should you have questions regarding these documents.

To facilitate your first visit to our office, please COMPLETE AND SIGN the following:

- *Patient Registration Sheet & Financial Policy (double-sided form)*
- *Clinical Information Sheet*

Please read through the Financial Policy carefully. You will need to bring these completed forms along with your insurance card(s), photo identification, required insurance referrals and arrive early for your first appointment. To ensure complete registration and to be in compliance with current federal and insurance regulations, we must adhere to these procedures.

We are pleased and honored to have been chosen as your orthopaedic healthcare providers. Thank you for placing your trust and confidence in us. We look forward to assisting you both now and in the future.

Sincerely,

Dr. J. Patrick Caulfield

Dr. Edward J. Bieber

Dr. Ira D. Fisch

Dr. Navin S. Sethi

Dr. Kurt C. Schluntz

Dr. Andre R. Gazdag

Dr. Mahidhar M. Durbhakula

Dr. Sridhar M. Durbhakula

UNDERSTANDING YOUR INSURANCE COVERAGE

Your insurance policy is an agreement between you and your insurance company. The policy lists a package of medical benefits such as tests, drugs and treatment services. The insurance company agrees to cover the cost of certain benefits listed in your policy. These are called "covered services."

Your policy also lists the kinds of services that are not covered by your insurance company. You have to pay for any uncovered medical care that you receive. Keep in mind that a medical necessity is not the same as a medical benefit. A medical necessity is something that your doctor has decided is necessary. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your doctor might decide that you need medical care that is not covered by your insurance policy.

Insurance companies determine what tests, drugs and services they will cover. These choices are based on their understanding of the kinds of medical care that most patients need. Your insurance company's choices may mean that the test, drug or service you need isn't covered by your policy.

Your doctor will try to be familiar with your insurance coverage so he or she can provide you with covered care. However, there are so many different insurance plans that it's not possible for your doctor to know the specific details of each plan. By understanding your insurance coverage, you can help your doctor recommend medical care that is covered in your plan.

- Take the time to read your insurance policy. It's better to know what your insurance company will pay for before you receive a service, get tested or fill a prescription. Some kinds of care may have to be approved by your insurance company before your doctor can provide them.
- If you still have questions about your coverage, call your insurance company and ask a representative to explain it.
- Remember that your insurance company, not your doctor, makes decisions about what will be paid for and what will not.
- Remember that your physician, not your insurance company, makes medical decisions and recommendations about what will benefit your health status.

Most of the things your doctor recommends will be covered by your plan, but some may not. When you have a test or treatment that isn't covered, or you get a prescription filled for a drug that isn't covered, your insurance company won't pay the bill. This is often called "denying the claim." You can still obtain the treatment your doctor recommended, but you will have to pay for it yourself.

If your insurance company denies your claim, you have the right to appeal (challenge) the decision. Before you decide to appeal, know your insurance company's appeal process. This should be discussed in your plan handbook. Also, ask your doctor for his or her opinion. If your doctor thinks it's right to make an appeal, he or she may be able to help you through the process.

Source: American Academy of Family Physicians, 2001

OrthoBethesda

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Please Print *This information is required by insurance companies.* Chart #_____

PATIENT NAME: First Middle Last ☐Dr. ☐Mr. ☐Mrs. ☐Ms.					HOME PHONE ( )
ADDRESS: Street Apt. # City State Zip Code					WORK / SCHOOL PHONE ( )
GENDER ☐ Male ☐ Female	DATE OF BIRTH	AGE	MARITAL STATUS	SOCIAL SECURITY NUMBER	CELL PHONE ( )
EMAIL ADDRESS					
OCCUPATION	PATIENT'S EMPLOYER / SCHOOL NAME AND ADDRESS				
EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT			PHONE NUMBER ( )	

If patient is under 18 years of age, please complete the following:

ACCOMPANYING ADULT'S NAME	RELATIONSHIP TO PATIENT	SIGNATURE

If patient is staying at a Skilled Nursing Facility, please complete the following:

FACILITY NAME	FACILITY ADDRESS	FACILITY PHONE NUMBER ( )

PERSON FINANCIALLY RESPONSIBLE (if other than patient):

NAME	PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY ☐ Child ☐ Spouse ☐ Other_____	HOME PHONE NUMBER ( )	WORK PHONE NUMBER ( )

CONDITION INFORMATION

INJURED BODY PART	SIDE ☐ Right ☐ Left	DATE PROBLEM BEGAN OR OF THE MOST RECENT FLARE-UP
PRIMARY CARE PHYSICIAN'S NAME	REFERRING **PHYSICIAN**, IF DIFFERENT	

AUTO ACCIDENT? STATE ☐ Yes ☐ No	WORK-RELATED ACCIDENT? STATE ☐ Yes ☐ No	OTHER ACCIDENT? ☐ Yes ☐ No	DATE OF ACCIDENT
IS AN ATTORNEY HANDLING THIS CASE? ☐ Yes ☐ No	NAME AND TELEPHONE NUMBER OF ATTORNEY ( )		DO YOU HAVE A LIVING WILL? ☐ Yes ☐ No

PLEASE CHECK APPROPRIATE BOX **HEALTH** ☐ **PIP / AUTO** ☐ **WORKERS COMP** ☐ **SELF-PAY** ☐

PRIMARY INSURANCE

INSURANCE COMPANY NAME	POLICY NUMBER	GROUP NUMBER	EFFECTIVE DATE	INSURANCE COMPANY PHONE ( )
INSURANCE ADDRESS: Street City State Zip Code			POLICY IN NAME OF	
PATIENT'S RELATIONSHIP TO INSURED	INSURED'S SOCIAL SECURITY #	INSURED'S DATE OF BIRTH	INSURED'S GENDER ☐ Male ☐ Female	INSURED'S EMPLOYER NAME

SECONDARY INSURANCE ☐ **Medigap** ☐ *Please Check*

INSURANCE COMPANY NAME	POLICY NUMBER	GROUP NUMBER	EFFECTIVE DATE	INSURANCE COMPANY PHONE ( )
INSURANCE ADDRESS: Street City State Zip Code			POLICY IN NAME OF	
PATIENT'S RELATIONSHIP TO INSURED	INSURED'S SOCIAL SECURITY #	INSURED'S DATE OF BIRTH	INSURED'S GENDER ☐ Male ☐ Female	INSURED'S EMPLOYER NAME

Patient Acknowledgment

I certify that the information I have reported above is true and correct. I authorize the release of any necessary information, including medical information, for this or any related claim to my insurance company in order to determine payable benefits. I request that payment of authorized benefits be made payable to OrthoBethesda on my behalf. I will notify this office of any changes in my health insurance coverage.

_____ _____

Signature of Patient, Policy Holder or Legal Guardian Date

Printed Name:_____

☐ I have received a copy of the Notice of Privacy Practices for OrthoBethesda.

☐ I have been offered a copy of the Notice of Privacy Practices for OrthoBethesda but did not want a copy.

Please read and sign the back of this form. ⇨

Patient Financial Policy & Consent to Treatment

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. We need *your* assistance and *your* understanding of our payment policy. Your insurance contract is between you, your employer and the insurance company. Not all services are covered by all contracts. While the filing of insurance claims for participating insurance carriers is a contractual obligation of the practice, all fees are ultimately the patient's responsibility. We will be happy to help you process your insurance claim form for reimbursement. For Medicare assignment and participating insurance plans, covered charges will be paid directly to us. We file to participating secondary payers one time only. If payment is not received within 45 days, we will send you a statement and payment will be expected at that time. This office cannot accept responsibility for negotiating a settlement on a disputed claim. If we do not participate in your insurance plan, you may still choose to be seen by the practice. We will require payment in full at the time services are rendered. As a courtesy to you, we will provide you with the documentation necessary for you to file with your insurance carrier on your own behalf.

Medicare Patients receiving Therapy Services: A reimbursement cap of $1880 is in effect for 2012 therapy claims filed with Medicare. There are exceptions provided for certain diagnoses, however. You may request assistance from our staff if you think you may be approaching your cap or you qualify for an exception. Once you have met the therapy cap for the year, you will be responsible for paying for the uncovered services.

We will estimate and collect patient balances, including co-payments, co-insurance and deductibles, on the day of the visit but will wait for the claim to be processed by the insurance plan, as applicable, before collecting the full amount due. Required insurance referral forms must be complete, current and presented at time of service. If you arrive for your appointment without valid, current insurance identification or a required referral, we will offer you the option of rescheduling your visit or making payment in full at the time services are rendered. All patients are encouraged to submit photo identification at the time of registration to enable OrthoBethesda to reduce the incidence of identity theft. We accept cash or checks, Visa, MasterCard, Discover or American Express. A fee of $35.00 will be charged for checks returned for insufficient funds or any other reason, whether issued directly by the patient or on the patient's behalf. An additional monthly fee will be charged on all past due accounts. Fees (which are generally not covered by insurance plans) will be charged for services such as copying of medical records and x-rays and the completion of insurance/physical forms. We require 24-hours notice (one full business day) if you wish to change or cancel your appointment. A $50 charge may be assessed for appointments missed without this notice. Patients who cancel or fail to show for three appointments will be discharged from the practice. We encourage you to contact us promptly for assistance in the management of your account. We are here to help you and will be happy to answer any questions you may have about your treatment or insurance coverage.

By signing below you are agreeing to the terms above, as they are written and without modifications, and are providing Bethesda-Chevy Chase Orthopaedic Associates, L.L.P. ("OrthoBethesda") consent to provide medical treatment.

_____ _____

Signature of Patient, Policy Holder or Legal Guardian Date

ORTHOBETHESDA

☐ J. PATRICK CAULFIELD, M.D. ☐ EDWARD J. BIEBER, M.D. ☐ IRA D. FISCH, M.D. ☐ KURT C. SCHLUNTZ, M.D.
☐ ANDRE R. GAZDAG, M.D. ☐ CHRISTOPHER J. CANNOVA, M.D. ☐ MAHIDHAR M. DURBHAKULA, M.D. ☐ NAVIN S. SETHI, M.D.
☐ SRIDHAR M. DURBHAKULA, M.D. ☐ THERAPY SERVICES

CLINICAL INFORMATION SHEET - Your insurance company **requires** that we obtain this information. Please fill out **completely!**

PATIENT'S NAME _____ HEIGHT_____ ft. _____ in. WEIGHT_____ AGE_____

GENDER_____ **IF FEMALE:** IS THERE ANY POSSIBILITY THAT YOU ARE ***PREGNANT***? ☐ Yes ☐ No

PRIMARY CARE (REFERRING) **PHYSICIAN** _____ REFERRING **PHYSICIAN** IF DIFFERENT _____

WE WILL SEND OFFICE NOTES TO THE ABOVE PHYSICIANS UNLESS OTHERWISE DIRECTED

ARE YOU STAYING AT A SKILLED NURSING FACILITY? ____ WHERE? _____ PHONE:_____

MEDICAL HISTORY: Please circle if you have, or have had, any of the following: ☐ NONE

1. Diabetes	5. Heart Arrhythmia	9. Heart Attack	13. Rheumatoid Arthritis	17. Stomach/Duodenal Cancer
2. Stroke	6. Coronary Heart Disease	10. High Cholesterol	14. Liver Disease	18. Gastro/Esoph/Acid Reflux
3. TIA (mini stroke)	7. High Blood Pressure	11. Depression	15. Kidney Disease	19. Pacemaker
4. Osteoarthritis	8. HIV/AIDS	12. Hepatitis	16. Cancer (type):_____	

OTHER _____

SURGICAL PROCEDURES: Have you ever had any surgery? ☐ YES ☐ NO If yes, please circle:

1. Heart Surgery	3. Vascular Bypass	5. Angioplasty	7. Appendectomy	9. Carotid Endarterectomy
2. Hernia Repair	4. Hysterectomy	6. Cancer Surgery_____	8. Gallbladder Surgery	Date of Surgery:_____

Please list any ***orthopaedic surgeries*** you have had: _____

REVIEW OF SYMPTOMS: Are you currently having, or have you ever had, problems with: ☐ NONE

Lungs or Breathing? ☐ Yes ☐ No Bleeding Disorders? ☐ Yes ☐ No Heart or Chest Pain? ☐ Yes ☐ No
GI Ulcers? ☐ Yes ☐ No Numbness or Tingling? ☐ Yes ☐ No

SOCIAL HISTORY:
Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No Do you exercise regularly? ☐ Yes ☐ No

MEDICATIONS: Do you take any medications, including aspirin and other non-prescription medications? ☐ Yes ☐ No
If yes, please list: _____

_____

ALLERGIES: Are you allergic to any medications, environmental substances, or metals? ☐ Yes ☐ No If yes, please list.

_____

WHAT PART OF THE BODY ARE YOU HERE FOR TODAY? _____ ☐ LEFT ☐ RIGHT
WHEN DID THIS PROBLEM BEGIN?* _____

*IF ONGOING, PLEASE INDICATE TIME PERIOD OF MOST RECENT EPISODE OR "FLARE-UP:"

_____

WAS THERE A SPECIFIC INJURY? ☐ Yes ☐ No **If yes, briefly describe incident: HOME WORK OTHER**
_____

PAST HISTORY – Have you had previous problems with this area? ☐ Yes ☐ No
If yes, please describe: _____

HAVE YOU SEEN ANY OTHER PHYSICIANS FOR THIS PROBLEM? ☐ Yes ☐ No Physician_____

WERE X-RAYS TAKEN? ☐ Yes ☐ No IF YES, DID YOU BRING THE X-RAYS WITH YOU? ☐ Yes ☐ No

WERE ANY OTHER TESTS PERFORMED? ☐ Yes ☐ No IF YES, DID YOU BRING THE TEST RESULTS WITH YOU? ☐ Yes ☐ No

***** The above is true and correct to the best of my knowledge.
PATIENT SIGNATURE _____ **DATE** _____

REVIEWED BY_____ DATE _____