Patient History

Date: _____

Credit Card Billing Authorization Form

As of March 17, 2014, a new office policy has been set in place. All patients are required to secure a credit card on file. We will be collecting your credit card at time of visit and storing it in a secure encrypted file with Key Bank. Nothing will be charged to this card at the time of visit unless instructed by the patient.

Your insurance will be billed as it always has been and you will receive an Explanation of benefits letter that will explain your visit to the office. The letter will explain what procedures were billed, what the insurance paid, and what the patient owes. For example; if there is a deductible or co-insurance on the insurance plan. We simply have to treat all patients the same. The amount owed is what will be charged to the credit card on file. You will be given a 2-3 week grace period to review your Explanation of Benefits letter and act on it accordingly. Should you choose not to pay your balance with the credit card on file, Kindly contact the office upon receipt of your Explanation of Benefits letter and simply inform the office that you wish to use a different form of payment (cash, check, or other credit card) Yes, we do accept assignment and only bill what the insurance instructs us to bill the patient.

Print Name:				
Personal Authorizing:				
Credit Card type:	☐ Visa	☐ MasterCard	☐ Discover	☐ Amex
Credit Card Number:				
Expiration Date:				

The undersigned agrees that all information provided to the applicable financial institution is accurate and complete. Deductible, Co-Pays, and Co-insurance are due in full at the time of service.

By completing and signing this form, you authorize Orhtopaedics Unlimited LLC to charge the patient responsibility that is set forth on the Explanation of Benefits from your insurance company that is not paid by your insurance company (the "Patient Responsibility"). The Explanation of Benefits from your insurance company determines the Patient Responsibility.

I have read this Credit Card Billing Authorization Form and a8ree to the terms and conditions set forth above. I hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of Orthopaedics Unlimited. Furthermore, l agree to sign all health insurance benefits directly to Orthopaedics Unlimited, and understand that I am responsible for any costs of Patient Responsibility not covered by my health insurance which shall be charged to the credit card as set forth above.

Print your Name_____ Signature_____ Date_____

Name: _____ Date: _____

Height: _____ Weight: _____

List current medications:

_____
_____
_____

Are you pregnant? _____ Do you smoke? _____ Drink alcoholic beverages_____ How much _____

List of allergies: _____
Allergies to medication: _____

Have you ever had the following medical conditions?

Abdominal breathing	Y N	High Blood Pressure	Y N
Alcohol/Drug abuse	Y N	HIV/Aids	Y N
Arthritis	Y N	Hospitalized	Y N
Artificial Joints	Y N	Kidney Problems	Y N
Valve Replacement	Y N	Liver Disease	Y N
Tuberculosis	Y N	Low Blood Pressure	Y N
Cancer/Chemotherapy	Y N	Mitral Valve	Y N
Congenital heart disease	Y N	Pacemaker	Y N
Diabetes	Y N	Psychiatric Problems	Y N
Emphysema	Y N	Radiation Treatment	Y N
Fainting Spells	Y N	Rheumatic/Scarlet Fever	Y N
Fever	Y N	Shingles	Y N
Frequent Headaches	Y N	Sickle Cell Anemia	Y N
Glaucoma	Y N	Sinus Pressure	Y N
Hay Fever	Y N	Stroke	Y N
Heart Surgery	Y N		
Hemophilia	Y N		
Hepatitis	Y N		
Herpes/Fever Blisters	Y N		

All of these questions have been answered completely and truthfully to the best of my knowledge.

Patient Signature: _____

Physician Review: _____

Michael H. Rieber, M.D.
Orthopaedics Unlimited
Patient information Form
Tel: 973 322 740O
Fax: 973 322 74Ol

☐ 200 So Orange Ave Suite 230
Livingston, NJ 07039
☐ 266-272 Chestnut Street
Newark, NJ 07105

First Name _____ Middle _____ Last Name _____

Address_____ City _____State_____ Zip Code_____

Home Telephone # _____ Cell# _____

Email: _____ Fax #_____

Date of Birth: _____ Sex _____ Marital Status _____

Age _____ Social Security # _____

Referring Physician_____ Other _____

Is this visit of a work or motor vehicle accident? Yes No

If yes provide Date of injury_____ Name of insurance company _____

Claim # _____ Address_____

Name of Adjuster _____ Phone _____ Fax _____

Insurance Information

Name of Company_____ Address _____

Phone # _____ ID # _____

Group # _____ Name of Insured _____

Relationship to Patient_____ SS # _____

Secondary Insurance _____ ID # _____

Group # _____ Policy Holder _____

Address _____Phone # _____

Pharmacy Name _____ Address _____

Phone # _____

Patient Portal Registration Form

We know you're busy. That's why Orthopaedics Unlimited is offering a way for you to manage your healthcare online.

Orthopaedics Unlimited Patients Portal is a convenient and easy-to-use online system that allows you to view your personal health information.

Orthopaedics Unlimited LLC Patient Portal is encrypted and password-protected, so health data remains secure.

Sign up and make managing your healthcare a little easier. To get started, please fill out the information below and return this card to the receptionist at the front desk.

_____

Print Patient's name

_____

Patient's Date of Birth

_____

Last 4 digits of Patient's SS# (*this will be used to confirm your identity when you create your account*).

_____

E-mail Address (*if the e-mail address provided belongs to someone other than the patient, please make sure that individual is listed on the authorization to Release Information consent*).

Fill out the four questions on this card and return it to the front desk at your physician's office.

Michael H. Rieber, M.D.
Orthopaedics Unlimited
Patient information Form
Tel: 973 322 740O
Fax: 973 322 74Ol

☐ 200 So Orange Ave Suite 230
Livingston, NJ 07039
☐ 266-272 Chestnut Street
Newark, NJ 07105

I certify that the information I have provided is accurate. I authorize the release of medical or other information required to process this claim. I understand I am responsible for any unpaid balances. I understand it is my responsibility to obtain any necessary referrals required by my insurance plan **Prior** to being treated by Orthopaedics Unlimited. **All Co Payments are required at time of visit. There is a $25.00 fee for Return Checks.**

Signature: _____ Date: _____

My insurance Carrier is _____. (I have been informed that Orthopaedics Unlimited is Non-Participating Provider with BCBS). All unpaid deductible amounts are required prior to treatment. A bill will be submitted to your insurance CO. on your behalf. **As the patient, and a "covered person" under mv health insurance policy. I direct mv insurance carrier that all checks in payment for medical services provided by Orthopaedics Unlimited, shall be made payable to the practice only, and that such payment checks shall not also be made payable to Michael H. Rieber, M.D."**

Signature: _____ Date: _____

Assignment of Benefits:
I irrevocably assign to Othopaedics Unlimited all my rights and benefits under any insurance contracts for payment of services rendered to me by Orthopaedics Unlimited. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by Orthopaedics Unlimited to be released to Orthopaedics Unlimited. I irrevocably authorize Orthopaedics Unlimited to file insurance claims on my behalf for services rendered to me. **I irrevocablv direct that all payments are made out to and so to Orthopaedics Unlimited only**. I irrevocably authorized Orthopaedics Unlimited to act on my behalf and report any suspected violations or improper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.
Signature: _____ Date: _____

I have read and understood the privacy policy of Orthopaedics Unlimited, **I DO / I DO NOT** Grant permission to release my medical information. Name of person Authorized to receive your medical information _____ Signature: _____