



# MERCER-BUCKS ORTHOPAEDICS PC

## PATIENT REGISTRATION

### PLEASE PRINT

Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Middle Name \_\_\_\_\_  
 Sex \_\_\_\_\_  
 Previous Last Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Social Security No. \_\_\_\_\_  
 Address \_\_\_\_\_  
 Zip \_\_\_\_\_ Email \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Mobile Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
 Marital Status \_\_\_\_\_  
 How did you hear about us? \_\_\_\_\_  
 \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Name \_\_\_\_\_  
 Relation \_\_\_\_\_  
 Phone ( \_\_\_\_\_ ) \_\_\_\_\_

### EMPLOYER INFORMATION

Name \_\_\_\_\_  
 Phone ( \_\_\_\_\_ ) \_\_\_\_\_

### GUARANTOR INFORMATION (to whom statements are sent)

Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Middle Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Zip \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
 Employer Name \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

### POLICY INFORMATION

Patient's relationship to policy holder \_\_\_\_\_  
 \_\_\_\_\_  
 ID/Certification No. \_\_\_\_\_  
 Policy/Group No. \_\_\_\_\_  
 Issue Date \_\_\_\_\_  
 Primary Care Physician \_\_\_\_\_

### POLICY HOLDER

Type of Insurance \_\_\_\_\_  
 Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Middle Name \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Sex M \_\_\_\_\_ F \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

### POLICY INFORMATION

Patient's relationship to policy holder \_\_\_\_\_  
 \_\_\_\_\_  
 ID/Certification No. \_\_\_\_\_  
 Policy/Group No. \_\_\_\_\_  
 Issue Date \_\_\_\_\_

### POLICY HOLDER

Type of Insurance \_\_\_\_\_  
 Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Middle Name \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Sex M \_\_\_\_\_ F \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



**AUTHORIZATION FOR RELEASE OF CONFIDENTIALITY & MEDICAL INFORMATION**

This authorization or photocopy thereof will authorize Mercer Bucks Orthopaedics to furnish all information they may have regarding my condition, while under their observation or treatment, to any party who may be responsible for payment to Mercer Bucks Orthopaedics, including the history obtained, X-ray and physical findings, diagnosis and prognosis.

In addition to release of information as authorized and in the interest of confidentiality with HIPAA (Health Insurance Portability and Accountability Act), your careful consideration and acknowledgement as to whom we may release information to on your behalf is required. This would pertain specifically to personal relations, i.e. family, friends, etc.

I authorize the release of medical information (health and demographics) as it pertains to my care only to the following. (You may contact our office at any time should you wish to make changes to this authorization)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS**

I assign the group physician benefits herein specified and otherwise payable to me to Mercer Bucks Orthopaedics, but not exceed Mercer Bucks Orthopaedics charge for this period of treatment. I authorize and request that payment be made directly to Mercer Bucks Orthopaedics. I understand and agree that regardless of my insurance coverage, I am financially responsible to Mercer Bucks Orthopaedics for charges not covered by my insurance company or this authorization. This assignment or photocopy is acceptable.

**MEDICARE AND MEDIGAP ASSIGNMENT OF BENEFITS**

I request that payment of authorized Medicare and/or Medigap benefits be made either to me or on my behalf to Mercer Bucks Orthopaedics for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I further authorize any holder of Medicare and/or Medigap information about me to release to Mercer Bucks Orthopaedics any information needed to determine benefits payable for related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, Mercer Bucks Orthopaedics agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services.

Date \_\_\_\_\_ Signature \_\_\_\_\_

Witness \_\_\_\_\_ Signature \_\_\_\_\_

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Form reviewed by: \_\_\_\_\_ Date \_\_\_\_\_

Copy of Insurance Card \_\_\_Y \_\_\_N

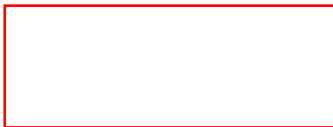
Verified Auto Accident \_\_\_Y \_\_\_N

*Entered demographics into system:*

Name \_\_\_\_\_ Date \_\_\_\_\_

NOTES: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



# Mercer-Bucks Orthopaedics, P.C.

*Diplomates American Board of Orthopaedic Surgery*

## NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

<p><b>PATIENT HEALTH INFORMATION</b> Under Federal Law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment billing, and insurance information.</p> <p><b>How We Use Your Patient Health Information:</b> We use health information about you for treatment to obtain payment and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.</p> <p><b>Examples of Treatment, Payment and Health Care Operations:</b> <b>Treatment:</b> We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment to pharmacists who are filling your prescriptions, and to family members who are helping with your care. <b>Payment:</b> We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. <b>Health Care Operations:</b> We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it. <b>Special Uses:</b> We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. <b>Other Uses and Disclosures:</b> We may use or disclose identifiable health information without your permission for the following purposes: <b>Required by Law:</b> We may be required by law to report gunshot wounds, suspect abuse or neglect,</p>	<p>or similar injuries or events. <b>Research:</b> We may use or disclose information for approved medical research. <b>Public Health Activities:</b> As required by law, we may disclose vital statistics, diseases, information related to recall of dangerous products, and similar information to public health authorities. <b>Health Oversight:</b> We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities. Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order. <b>Law enforcement purposes:</b> Subject to certain restrictions, we may disclose information required by law enforcement officials. <b>Deaths:</b> We may report information regarding deaths to coroners, medical examiners, funeral directors and organ donation agencies. Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or health and safety of the public or another person. <b>Military and Special Government Functions:</b> If you are a member of the armed forces, we may release information to correctional institution to correctional institutions or for national security purposes. <b>Worker's Compensation:</b> We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illnesses. If any other situation, we will ask for your written authorization before using or disclosing any identifiable health information, you can later revoke that authorization to stop any further uses and disclosures.</p> <p><b>INDIVIDUAL RIGHTS</b> You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights. <b>Request Restrictions:</b> You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restriction, but if you do agree, we must abide by those restrictions.</p>	<p><b>Confidential Communications:</b> You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments. <b>Inspect and Obtain Copies:</b> In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies. <b>Amend Information:</b> If you believe that information in your records is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add missing information. <b>Accounting of Disclosure:</b> You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care operations. <b>Our Legal Duty:</b> We are required by Law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. <b>Changes of Privacy Practices:</b> We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below: <b>Complaints:</b> If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You may also send a written complaint to the US Department of Health and Human Services. This person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint. <b>Contact Person:</b> If you have any questions, requests or complaints, please contact: <b>Constantine A. Solomos, MBA, CMPE</b> <b>C.E.O.</b> <b>3130 Princeton Pike</b> <b>Lawrenceville, NJ 08648</b> <b>609-896-0444</b></p> <p>I, _____ hereby acknowledge receipt of the Notice of Privacy Practices given to me.</p> <p>Signed _____</p> <p>Date _____</p> <p>If not signed, reason why acknowledgement was not obtained: _____ _____</p> <p>Staff Witness seeking acknowledgement _____ _____</p> <p>Date _____</p>
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**Mercer-Bucks Orthopaedics, P.C.**

*Diplomates American Board of Orthopaedic Surgery*

Daren J. Aita, M.D.  
Thomas K. Bills, M.D., Ph.D.  
Paul W. Codjoe, M.D.  
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Edward J. Ford, M.D.  
Sandro LaRocca, M.D.  
John P. Nolan, Jr. M.D.  
Rikin J. Patel, DO

I \_\_\_\_\_ have informed Mercer-Bucks Orthopaedics that the treatment/services I am receiving starting \_\_\_\_\_ are not the result of an a automobile accident. The injuries for which I am seeking treatment/services do not arise out of the ownership, operation, maintenance, use of an automobile or as a pedestrian.

I \_\_\_\_\_ understand that by my notifying Mercer-Bucks Orthopaedics that the injuries are not automobile related, no notification or claim will be sent to my automobile insurance company. Therefore, any bills incurred but not covered by my personal health insurance will be my personal responsibility and obligation to pay. Payment is expected upon receipt of services.

We at Mercer-Bucks Orthopaedics ask that you sign this document only after any questions you may have concerning its content have been answered to your satisfaction and you understand your obligation to pay for any unpaid services by your insurance carriers.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office Manager





\* - 5 \*



<b>Family History</b>	Age	Major Illnesses	If deceased, cause of death
Mother	_____	_____	_____
Father	_____	_____	_____
Brother/Sister	_____	_____	_____
Brother/Sister	_____	_____	_____
Son(s)	_____	_____	_____
Daughter(s)	_____	_____	_____
Family History of Arthritis?	No_____ Yes_____	Which family member?_____	Type _____

**Social History**

Marital Status    Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_

Use of Alcohol    Never \_\_\_\_\_ Rarely \_\_\_\_\_ Moderate \_\_\_\_\_ Daily \_\_\_\_\_

Use of Tobacco    Never \_\_\_\_\_ Previously but quit \_\_\_\_\_ Current packs/day \_\_\_\_\_

Are you right or left handed? \_\_\_\_\_ Living Situation: Alone \_\_\_\_\_ with Spouse/Family \_\_\_\_\_ with Friends \_\_\_\_\_

Hobbies and sport activities you enjoy \_\_\_\_\_

Type of work \_\_\_\_\_

Are there religious/cultural needs related to your care? (Please circle) No Yes

Please explain:

**Systems Review**

(Did you have any of the following symptoms within the past 6 months?)

**Constitutional Symptoms**

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes

**Hematologic/Lymphatic**

Anemia	No	Yes
Phlebitis	No	Yes
Past blood transfusion	No	Yes
Exposure to HIV	No	Yes
History of Blood Clots	No	Yes

**Musculoskeletal**

Osteoporosis	No	Yes
History of fractures	No	Yes
History of gout	No	Yes
Rheumatoid disease	No	Yes

**Gastrointestinal**

Loss of appetite	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Rectal bleeding	No	Yes
Abdominal pain or heartburn	No	Yes
Peptic ulcer	No	Yes
Hepatitis	No	Yes

**Neurological**

Lightheaded or dizzy	No	Yes
Tremors	No	Yes
Paralysis	No	Yes

**Psychiatric**

Depression	No	Yes
Memory loss or confusion	No	Yes
Insomnia	No	Yes
Nervousness	No	Yes

Reviewed by Dr. \_\_\_\_\_

Date \_\_\_\_\_

Patient's Signature \_\_\_\_\_



# MERCER-BUCKS ORTHOPAEDICS

## FINANCIAL RESPONSIBILITY AGREEMENT

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance company for my visits. This includes any Medical service visit, X-ray, EMG, OMT, DME or Therapy services ordered by my physician or my physician's staff.

I understand and agree it is my sole responsibility and not the responsibility of the provider of services, hospital, surgery center, therapists or supplier to know if my insurance will pay for my Medical service or visit, X-ray, EMG, OMT, DME or Therapy services ordered by my physician or my physician's staff.

I understand and agree it is my sole responsibility to know if my insurance has any Deductible, Referral Requirement, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit or any other type of benefit limitation for the services I receive, and I agree to make full payment promptly.

I understand that it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied, or higher out-of-pocket expense to me. I understand this and agree to be financially responsible and make full payment promptly.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment promptly.

By signing below, I agree to accept full financial responsibility as a patient who is receiving Medical services, X-rays, EMG, OMT, DME or Therapy services or as the responsible party for minor patients. My signature verifies that I have read the above disclosure statement, understand my responsibilities, and agree to these terms.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party Name (please print) \_\_\_\_\_

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_