Mountain Valley ORTHOPEDICS
THE STRENGTH OF EXPERIENCE

Patient Registration - Financial Policy and Privacy Statement

Insurance Patients I Patients must present valid health insurance and a government-issued ID at the time of service. Co-pays are due at the appointment. We will submit eligible claims to insurance as a courtesy. Patients are responsible for understanding their coverage and should contact their insurer with any questions. Remaining balances after insurance processing must be paid within 30 days. Claims related to work injuries or motor vehicle accidents may not be covered by standard health insurance.

Self-Pay Patients I Self pay patients are required to pay in full at the time of service. Self-pay patients are responsible for the office visit fee plus any additional services performed during the appointment. These include, but are not limited to: x-rays, casts, splints, injections, etc. A self-pay price list is available at the front desk, and all self-pay patients will be informed of any additional charges prior to performance of a service.

Workers Compensation I Charges for treatment of verified work-related injuries will be billed to the appropriate workers' compensation carrier, pending prior claim authorization. If a claim is denied or the injury is deemed non-occupational or unreported, the patient is financially responsible, either through personal insurance or direct payment.

Motor Vehicle Accidents I Per company policy, Patients must disclose if their visit or treatment is related to a motor vehicle accident at the time of scheduling. The name of the insurance company handling the claim must be provided along with the claim number, date of accident and name and contact information of the insurance adjuster. All claims will be verified prior to being seen. If the claim cannot be verified prior to the appointment, the appointment will be rescheduled, or the patient may elect to be seen as a self-pay patient, and payment will be due at time of service.

Missed Appointments I A $25 fee will be charged for all missed office visits or cancellations without notice. This charge is not covered by the insurance and is the responsibility of the patient.

Authorization to Release Information I authorize the release of medical information to all providers involved in my care and to my insurance company for billing and payment purposes.

Medical Records I Medical records are processed through an outside medical records company, HealthMark. To obtain records you must complete a medical records request form. The form will be submitted to HealthMark who will contact you regarding payment. Once payment is received the records will be released as requested. Fees are per page. Processing time averages 5-7 business days, however be advised it may take up to 30.

Disability Forms I Disability forms are processed through HealthMark, and there is a $30 fee for each form. It is the patient's responsibility to obtain and provide our office with the form. The forms will be submitted to HealthMark who will contact you regarding payment. Once payment is received the forms will be submitted as requested.

Collection Accounts I Our office will make every effort to communicate with you about your account and will present reasonable options for payment. In the event that we involve a third party for collection of an account, you will not be permitted to return for a new episode of care until you have satisfied the old debt.

Although Pennsylvania law may permit filing lawsuits or legal action in other places, I agree that any lawsuits or legal action which is in any way linked to the health care that I receive from Mountain Valley Orthopedics, PC or its agents/employees must be filed in a County in which the health care at issue received from Mountain Valley Orthopedics, PC and/or its agents/employees was given.

I have read the Financial Policy as outlined above.

Privacy Statement I have received a copy of the Protected Health Information. I give permission to Mountain Valley Orthopedics, P.C. to use and disclose my health information in accordance with it. _____

Initials

_____ _____ ____/____/_____

Patient Name **Signature** **Date**

(Office use only _____ Refused to sign _____Refused Copy of Privacy Notice)

Name:_____**Sex**: M F **DOB**:___/____/____

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SSN # _____/ _____/_____ **Email:**_____@ _____. _____

Address: _____ **City:**_____ **State/Zip**:_____

Home Phone:( ) _____ **Cell Phone: ( )** _____ **Work Phone**: ( ) _____

Contact Preference: Home Cell or Work

Race
☐ African American or Black
☐ Alaska Native or American Indian
☐ Asian
☐ Pacific Islander or Native Hawaiian
☐ White

Ethnicity
☐ Hispanic **Language**: _____
☐ Other
☐ Decline **Marital Status**: M S D W

How Did You Hear About Us?

☐ Advertising	☐ Hospital Emergency Room	☐ Radio Ads	☐ Website
☐ Bill Board	☐ Insurance Company	☐ Self-Referral	
☐ Community Event-Talk	☐ News Paper Ad	☐ TV Ads	
☐ Family Friend	☐ Primary Care Physician	☐ Specialist Physician _____	

Pharmacy_____

Patient Condition Related to: (___) Employment, state _____ (___) Auto Accident (___) Other Accident (___) N/A

Assignment of Benefits/ Release of Billing Information

I authorize Mountain Valley Orthopedics and/or their staff to leave medical information pertaining to my care by phone, voicemail, and to contact me via email for appointment reminders and office newsletters.

I request that payment of services from Medicare/ Medigap benefits be made to Mountain Valley Orthopedics, P.C. I authorize any holder of medical information about me to be released to all providers involved in my care and to my insurance company for the purpose of processing and reimbursement for services rendered. I acknowledge that I am responsible for payment of any balance not covered by my insurance company.

I authorized for medical information about me to be released to all providers involved in my care and to my insurance company for the purpose of processing and reimbursement of services rendered.

I also authorize the release of medical information pertaining to my medical care to the following individuals:

Name:_____ **Phone:**_____ **Relationship:**_____

Name:_____ **Phone:**_____ **Relationship:**_____

☐ Check here if you do not wish your medical information to be released to any individuals.

Guardian (if patient under 18): Last name**:** _____**,** First name**:** _____

Emergency Contact Name: _____ **Relationship:** _____

Home phone: (_____) _____ **Mobile phone: (_____)** _____

Next of Kin Name: _____ **Relationship:** _____

Phone: (_____) _____

Employer Name of Policy Holder: _____ **Phone #: (_____)** _____

Occupation: _____**Name of Policy Holder**:_____

DOB: ____/____/____ **Relation to Patient:** Self Child Spouse Other:_____

Consent for Treatment- I hereby authorize Mountain Valley Orthopedics to provide evaluation and medical treatment necessary, including diagnostic, surgical and/or therapy interventions, by authorized member of practice or their designee.

_____ _____ ____/____/_____
Patient Name **Signature** **Date**