

Orthopedics

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Edward J. Whelan, III, M.D.

Leslie L. Wilkes, M.D.

James W. Wilson, Jr., M.D.

Kent E. Woo, M.D.

Interventional Pain Management

Joseph C. Hegarty, M.D.

Andrew B. Pandya, M.D.

Priscilla J. Ross, M.D.

Chief Executive Officer

Michael W. Kleinpeter



Welcome to our New Patient!

Thank you for choosing Southeastern Orthopedic Center. We are looking forward to your visit with us:

Patient's Name: _____

Date of Appointment: _____

With Physician: _____

Appointment Time: _____

Office Location: _____

If you are unable to keep this appointment, please phone us immediately at the appropriate office location phone number shown on the left.

Please complete the paperwork attached BEFORE your visit and bring it with you on your appointment date. This will reduce the amount of waiting time you experience upon your arrival.

It is important that you bring:

any x-rays or MRI film that may have been done at another facility as some insurance companies will not pay for additional x-rays to be taken and our doctor will need these on your first visit.

We look forward to seeing you!

Note: We now offer Urgent Care at several locations:

*Savannah: Monday thru Friday 5:00pm – 9:00pm
Saturday 9:00am – 1:00pm
Sunday 1:00pm – 5:00pm
No Appointment Necessary*

*Vidalia: Monday thru Friday 5:00pm – 9:00pm
No Appointment Necessary*

Baxley
110 East Tollison St.
Baxley, GA 31513
(800) 827-6536

Claxton
209 N. River St.
Claxton, GA 30417
(800) 827-6536

Dublin
230 Industrial Blvd., Ste. 7
Dublin, GA 31021
(800) 827-6536

Glenwood
322 East 2nd Ave.
Glenwood, GA 30428
(800) 827-6536

Hazlehurst
17 Johnson Street
Hazlehurst, GA 31539
(912) 681-2500

Hinesville
1146 E.G. Miles Pkwy.,
Ste. 102
Hinesville, GA 31313
(800) 827-6536

Metter
380 Cedar St.
Metter, GA 30439
(912) 681-2500

Millen
415 College Ave.
Millen, GA 30442
(912) 681-2500

Okatie, SC
16 Okatie Center Blvd., South
Suite 201
Okatie, SC 29909
(843) 837-1020

Pooler
101 W. Mulberry Blvd.,
Ste. 140
Pooler, GA 31322
(912) 748-5111

Reidsville
247A South Main St.
Reidsville, GA 30453
(800) 827-6536

Richmond Hill
60 Exchange Street, Ste. B-7
Richmond Hill, GA 31324
(800) 827-6536

Rincon
810 Towne Park Dr.,
Ste. 200
Rincon, GA 31326
(912) 826-2533

Savannah
210 E. DeRenne Ave.
Savannah, GA 31405
(912) 644-5300

Springfield
459 GA Hwy. 119 South
Springfield, GA 31329
(800) 827-6536

Statesboro
16915 Suite A
US Hwy. 67 South
Statesboro, GA 30458
(912) 681-2500

Sylvania
215 Mims Rd.
Sylvania, GA 30467
(800) 827-6536

Tifton
1622 Madison Ave.
Tifton, GA 31794
(229) 388-5625

Twin City
115 Gillikin Street
Twin City, GA 30471
(800) 827-6536

Valdosta
2804 D North Oak Street
Valdosta, GA 31602
(229) 249-9626

Vidalia
3301 East First St., Ste. B
Vidalia, GA 30474
(912) 537-0888

Name: _____

Chart: _____

Date: _____

Provider: _____

ACCIDENT DETAILS

PATIENT'S NAME _____ DATE OF BIRTH _____

Is your visit today the result of a work-related or auto accident? YES NO

If YES, which one?: Work-Related AUTO ACCIDENT

Signature of patient or guardian _____ Date _____

If YES, please complete the following:

1. **What** happened?
2. **Where** did the accident occur?
3. **When** did the accident occur? (DATE)
4. Is there any other insurance coverage (such as a homeowner's policy, school insurance, worker's compensation, etc.) that will pay this bill ? YES NO

a. If YES, please give us the information in the space provided for that insurance company:

NAME OF COMPANY	INSURED'S NAME	
INSURANCE COMPANY ADDRESS		
CITY, STATE, ZIP		
PHONE	POLICY #	CLAIM #

ATTORNEY'S NAME _____ ADDRESS _____ PHONE _____

IF WORK RELATED:

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

WAS INJURY REPORTED TO EMPLOYER? YES NO

If YES, list the name of the person you spoke with _____ PHONE _____

AUTO ACCIDENT/OTHER ACCIDENT

When your injuries are the result of an accident and an attorney will be handling your case in court or another party's insurance company is presumed responsible for your charges, the patient is still responsible for payment of the bill. Orthopedic Center cannot be expected to wait for the conclusion of long-term court case or settlement of a disputed insurance claim before being paid. **You will be required to make a payment of \$250 before being seen and with each visit that follows. You also are responsible for payment of the balance of your bill should charges exceed the \$250 you pay at each visit.**

WORKER'S COMPENSATION

Patients who are injured on the job should report the injury directly to their employer. The employer will be responsible for directing the employee to a doctor who is listed on their Panel of Physicians. Before we will be able to see you as a patient, we will require you to fax or bring in a letter verifying that your employer will be responsible for your charges. If a patient comes in for a visit without this information, we will have to reschedule the appointment. This information is necessary to avoid the patient being responsible for the bill.

Signature of patient or guardian _____ Date _____

Name: _____

Chart: _____

Date: _____

Provider: _____

SOUTHEASTERN ORTHOPEDIC CENTER - PATIENT INFORMATION & HISTORY FORM

Patient Name _____ Sex _____
LAST FIRST MIDDLE

Patient's Date of Birth _____ Age _____ Patient's Social Security # _____
Month Day Year

Home Address _____ Apt# _____ Lot# _____
Street City State Zip

Mailing Address _____
City State Zip

Is this address: permanent temporary (check one) Patient's Marital Status Single Widowed Divorced Married

Home Phone _____ Work Phone _____ Cell Phone _____

E-Mail address _____ Race _____ Ethnicity Hispanic Non Hispanic Unknown

If Patient Lives in a Nursing Home or Assisted Living Facility, please provide below: Primary Language _____
Name of Facility _____ Address _____ Phone _____

EMERGENCY INFORMATION

EMERGENCY CONTACT NAME _____ RELATIONSHIP TO PATIENT _____ Phone _____

NEAREST FRIEND NOT LIVING WITH YOU _____ Phone _____

MEDICARE/MEDICAID

MEDICARE NO: _____

EFFECTIVE DATE ____ / ____ / ____

MEDICAID NO: _____

DATE OF MONTH ELIGIBLE ____ STATE ISSUED ____

PRIMARY Insurance Information

Name of Insurance Company _____

Address of Insurance Co _____

Policy # _____ Group # _____

SUBSCRIBER'S NAME _____ (as on insurance card)

Relationship to Patient: Self Spouse Child Other _____

SUBSCRIBER'S ADDRESS _____

CITY, STATE _____, _____ ZIP _____

PHONE _____

DATE OF BIRTH ____ / ____ / ____ SEX Male Female

Social Security # of Insured ____ / ____ / ____

Name of Insurance Company _____

Address of Insurance Co _____

Policy # _____ Group # _____

SUBSCRIBER'S NAME _____ (as on insurance card)

Relationship to Patient: Self Spouse Child Other _____

SUBSCRIBER'S ADDRESS _____

CITY, STATE _____, _____ ZIP _____

PHONE _____

DATE OF BIRTH ____ / ____ / ____ SEX Male Female

Social Security # of Insured ____ / ____ / ____

SPOUSE OR GUARDIAN INFORMATION

Name _____

SSN _____ DOB ____ / ____ / ____

Address of Spouse or Guardian _____ City _____ State _____ Zip _____

Spouse or Guardian's Employer _____

Employer's Address _____ City _____ State _____ Phone _____

If Patient is under 18 years of age, please state your relationship to the patient: _____

WHO IS YOUR FAMILY PHYSICIAN? _____ WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

WHAT IS YOUR OCCUPATION? _____ NAME OF PATIENT'S EMPLOYER _____

EMPLOYER'S ADDRESS _____

CITY, STATE _____ EMPLOYER'S PHONE _____

Name:

Chart:

Date:

Provider:

PATIENT RECORD OF DISCLOSURES

In general, HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner:

(check all that apply):

Work Telephone

o.k. to leave message with detailed information

leave message with call-back number only

Home Telephone

o.k. to leave message with detailed information

leave message with call-back number only

Written Communication

o.k. to mail to my home address

o.k. to mail to my work/office

o.k. to fax to this telephone number _____

You may leave messages with, discuss my treatment, appointments or other scheduling that may occur or give other information as necessary with the following family, friends or personal representatives. You may release a copy of my medical records to the person(s) listed below. I understand that Orthopedic Center, PC will refuse to discuss my information with anyone not listed below, except in an emergency. I also understand that this consent does not apply to medical providers.

PLEASE PRINT

1. _____
2. _____
3. _____
4. _____
5. _____

Patient's signature _____ **Date** _____

Please print name _____

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Orthopedic Center, PC Notice of Privacy Practices, detailing how information may be used and disclosed as permitted under federal and state law.

Signed _____ **Date** _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed by: _____

(FOR INTERNAL USE)

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign here:

Presented by _____ (name & title)
Date _____ Time _____

Name:

Chart:

Date:

Provider:

NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

Effective April 14, 2003

The following is the privacy policy of Orthopedic Center, PC DBA Southeastern Orthopedic Center (SOC) and Tattnall Hospital Company, LLC DBA The Doctor's Hospital of Tattnall (TDHT) ("Covered Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms of that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collections activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization, review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health operations include: (a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. Examples of instances in which we are required to disclose your personal health information include: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization or, if you provide the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities Notice

We may contact you to provide appointment reminders or information about treatment alternatives of other health-related and services that may be of interest to you. We may contact you to raise funds for Covered Entity.

Name:

Chart:

Date:

Provider:

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. You may request restrictions on the following uses or disclosures: to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit information from us by alternative means or at alternative locations.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy of your personal health information contained in your designated record set, except for (a) psychotherapy notes, (b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form format, or if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request information, information as to which we have a ground to deny access, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to Privacy Officer, 210E.DeRenne Avenue, Savannah, GA 31405.

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. We are not required to provide accountings of disclosures for the following purposes: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within the same twelve (12) month period. All requests for an accounting shall be sent to Privacy Officer, 210E.DeRenne Avenue, Savannah, GA 31405.

Complaints

You may file with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our Privacy Officer, 210E.DeRenne Avenue, Savannah, GA 31405, 912.644.5300. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you know or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access To Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to Privacy Officer, 210E.DeRenne Avenue, Savannah, GA 31405. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our Privacy Officer at the address, telephone number listed above.

Name:

Chart:

Date:

Provider:

PATIENT CONSENT TO THE USE & DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I, _____ understand that as part of my healthcare, Southeastern Orthopedic Center, The Doctors Hospital of Tattall originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that the information serves as:

- a basis for planning my care and treatment,
- a means of communication among the many health professionals who contribute to my care,
- a source of information for applying my diagnosis and surgical information to my bill,
- a means by which a third-party payer can verify that services billed were actually provided and
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- the right to review the notice prior to signing this consent
- the right to object to the use of my health information for directory purposes, and
- the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Southeastern Orthopedic Center, The Doctors Hospital of Tattall is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the code of Federal Regulations.

I further understand that Southeastern Orthopedic Center, The Doctors Hospital of Tattall reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Southeastern Orthopedic Center, The Doctors Hospital of Tattall change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. Mail or if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

Patient's Signature

Date

FOR OFFICE USE ONLY

- consent received by _____ on _____
- consent refused by patient and treatment refused as permitted.
- consent added to the patient's medical record _____

Name:

Chart:

Date:

Provider:

PAYMENT POLICY

The doctors and staff of Southeastern Orthopedic Center, The Doctors Hospital of Tattnell Physical/Hand Therapy are committed to providing our patients with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this, we need your assistance and understanding of our payment policy.

All services are provided for a fee for service basis unless you are associated with a managed care plan. In the case of a managed care plan, you will be required to pay your co-pay only. Payments for office visits, insurance co-pays and deductibles are expected when the service is rendered. We accept cash, personal checks or credit cards.

AUTO ACCIDENTS/OTHER ACCIDENTS

When your injuries are the result of an accident and an attorney will be handling your case in court or another party's insurance company is presumed responsible for your charges, the patient is still responsible for payment of the bill. Southeastern Orthopedic Center, The Doctors Hospital of Tattnell Physical/Hand Therapy cannot be expected to wait for the conclusion of long-term court cases or settlement of a disputed insurance claim before being paid.

WORKER'S COMPENSATION

Patients who are injured on the job should report the injury directly to their employer. The employer will be responsible for directing the employee to a doctor who is listed on the PANEL OF PHYSICIANS. Before we will be able to see you as a patient, we will require you to fax or bring in a letter verifying that your employer will be responsible for your charges. If a patient comes in for a visit **without** this information, we will have to **reschedule** the appointment. This information is necessary to avoid the patient being responsible for the bill.

MEDICAID

Please bring a copy of your Medicaid card to each visit; otherwise we will have to bill you directly. You will be responsible for all services not covered by Medicaid. This will include certain supplies and any office visits made after your twelve (12) authorized visits.

INSURANCE

Your insurance coverage is a contract between you and your insurance company. As a courtesy, we will file your office and surgery charges and all Medicare services with your insurance carrier. You may be requested to pre-pay your unmet deductible and co-insurance prior to any surgery performed or following emergency services.

You will continue to receive a statement each month even though your insurance is pending. Southeastern Orthopedic Center, The Doctors Hospital of Tattnell Physical/Hand Therapy cannot accept the sole responsibility for collecting your claim or negotiating a settlement on a disputed claim since we are not a party to your insurance contract. If you have a question regarding your account or the filing of your insurance, call The Doctors Hospital of Tattnell and ask for the Insurance Department. We will be happy to assist you.

If you need to set up an extended payment arrangement, contact our Insurance Department. If no payment has been received after 90 days from the date the services were rendered, necessary collection procedures through Equifax will begin.

AUTHORIZATION FOR SERVICES

The signature below serves as authorization for services rendered by Southeastern Orthopedic Center, The Doctors Hospital of Tattnell Physical/Hand Therapy for the above named patient, and release of information for payment of services, treatments, and/or operational purposes; and assigns benefits otherwise payable to policy holder to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by the insurance carrier-a copy of the signature is as valid as the original.

AUTHORIZATION FOR RELEASE OF INFORMATION

The signature below serves as authorization for Southeastern Orthopedic Center, The Doctors Hospital of Tattnell Physical/Hand Therapy to release or receive medical information for the purpose of patient referral. A copy of this signature is as valid as the original.

Date _____

Signature _____