VALLEY ORTHOPAEDIC SPECIALISTS

Main Office:
2 Trap Falls Rd, Ste 404
Shelton, CT 06484
Phone: (203) 734-7900
Fax: (203) 513-3269

Oxford Office:
220 Main St, Ste 1F
Oxford, CT 06478
Phone: (203) 734-7900
Fax: (203) 463-8957

Fairfield Office:
1275 Post Rd, Ste 208
Fairfield, CT 06824
Phone: (203) 955-1202
Fax: (203) 955-1203

www.vosct.com

Patient Registration Form

Patient Information **Date of Appointment:** _____

Patient's First Name	Middle Name	Last Name (as it appears on insurance card or ID)	
Sex Male ☐ Female ☐ / Marital Status	Date of Birth	How did you hear about us?	
Patient's Address	City	State	Zip
Home Phone	Mobile Phone	Email Address	
Emergency Contact	Emergency Contact's Phone	Relationship to Patient	
Employer/School	Occupation	Employer/School Phone	
Employer/School Address	City	State	Zip
Primary Care Physician Name	Pharmacy Name	Pharmacy City, State	

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.
(By signing the bottom of this notice you are agreeing to the terms and conditions summarized below)

- Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office, or going to our Website. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- By signing below, I understand that my records may contain information regarding diagnosis or treatment of specific disease including psychiatric, drug and/or alcohol abuse, sexually transmitted diseases, HIV test results, and related information. I give my specific authorization for these records to be released.
- I AUTHORIZE Valley Orthopaedic Specialists, LLC to leave automated reminder phone messages regarding my appointments on either my home or cell phone or contact me via e-mail or text.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.
- I give **CONSENT FOR MEDICAL TREATMENT** for myself or for the patient who I am a parent, legal guardian, power of attorney, or appointed patient respresentative. I also understand that if the patient is a minor (under the age of 18), a parent or a legal guardian must attend all appointments.
- **ASSIGNMENT OF MEDICAL BENEFITS/GUARANTEE OF FINANCIAL RESPONSIBILITY.** I request that payment of authorized medical benefits be made directly to VALLEY ORTHOPAEDIC SPECIALIST, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I AM FINANCIALLY RESPONSIBLE for all charges whether or not paid for by said insurance. In the event that I fail to pay charges due, and Valley Orthopaedic Specialists, LLC refers my account to collection, I agree to pay costs of collection including a reasonable attorney fee.
- **ACKNOWLEDGEMENT OF NOTICE OR PRIVACY PRACTICES**. "I hereby acknowledge that I have received a copy of this practice's notice of privacy practices. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer directly at 203-734-7900. I further understand that the practice will offer me updates to this notice of privacy practice should it be amended, modified, or changed in any way."

Patient/Parent or Legal Guardian (Please Print)

_____ **Date:** _____

Patient/Parent or Legal Guardian Signature

_____ **Date:** _____

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Financial Policy

Thank you for choosing VOS as your health care provider. We are committed to the successful treatment of your condition. Payment of your bill is considered part of your treatment and a clear understanding of our financial policy is important to our professional relationship. We will bill your insurance as a courtesy to you with a copy of your current insurance card. If you do not have your insurance card, full payment is due at the time of service. We accept cash, check, credit, and debit cards. There will be a $25 charge for returned checks. If payment is not received from your insurance carrier within our contract limits, any balance will be your responsibility.

Medicare: We accept Medicare assignment. As a Medicare patient you are responsible for your deductible and for the difference between the approved charge and the amount Medicare pays. If you have supplemental insurance we will bill it for you. Any remaining balance will be billed to you.

HMO/PPO/Commercial: All co-payments are due at the time of service. We are members of most, but not all plans. You are responsible for verifying what your insurance plan will cover and that we are providers for your plan.

Medicaid: VOS is a closed-network provider for Medicaid. We accept Medicaid patients when they are medically necessary referrals from Griffin Hospital during our On-Call hours only. If Medicaid is a secondary insurance all Medicaid cost-shares are collected at the time of service. VOS Pain Management and Physical Therapy are out-of-network with Medicaid, so co-pays and primary cost shares are applicable.

Workers Compensation: If you are here as a result of work related injury, we will require information regarding both health insurance and your employers Workers Compensation insurance. We will require a letter or statement authorizing your treatment from your employer or WC carrier. The letter should include the claim number, address, adjusters name and phone number. Your employer's human resource office should be able to assist you with obtaining this information. If payment is not received, the balance is your responsibility.

Accident Claims: If you are here as a result of an auto related injury, we will require information regarding both health insurance and your auto insurance. We will require a letter or statement authorizing your treatment from your auto insurance. The letter should include the claim number, address, adjusters name and phone number. Your auto insurance agent should be able to assist you with obtaining this information. If payment is not received, the balance is your responsibility.

No Show/ Same day Cancellations: There is a $50 no-show/ late-cancellation fee for scheduled appointments. All appointments must be cancelled by 3 p.m. of the previous day (or by 3 p.m. on Friday for a Monday appointment), to avoid charges for a no-show or late-cancellation. There is a $150 no-show / same-day cancellation fee for procedures (incl. injections) and surgeries. Insurance will not cover charges for no-show/late-cancellation fees.

UCR (USUAL AND CUSTOMARY RATE): We are committed to provide the best treatment possible for our patients and we charge what is usual and customary for our area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determination of UCR rates.

Self-Pay: A minimum deposit of $200 or the actual charges, whichever is less, is due at the time of service for all self-pay patients. Currently VOS offers a 20% prompt pay discount on charges paid in full at time services are rendered. Any subsequent visit charges will be due at time of service. If you cannot pay in full, you will need to set up and adhere to a payment plan with our billing department. We accept Visa, Master Card, Discover, American Express, Checks and Cash.

Delinquent accounts: Delinquent accounts may be assigned to a collection agency. All collection costs will be added to your outstanding balance. We cannot be involved in negotiating payment for divorce orders for medical bills. Whichever parent brings the minor child in for treatment will be responsible for payment of the bill regardless of your divorce decree.

Forms Completion/Medical Records Requests: From time to time various forms including but not limited to disability and FMLA forms need to be filled out. ***There will be a charge to complete these forms***. There is a nominal fee for copying medical records in accordance with the state allowance. There is a $5.00 per film charge to copy x-rays.

Consent for Medical Treatment: I authorize physicians and personnel to render medical treatment and evaluation if needed for this appointment and all future appointments. I further authorize X-rays, injections, casting, or other diagnostic tests and treatments that may be necessary.

I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment of my account with VOS and have provided to the best of my ability the information requested accurately and completely.

Signature: _____ **Date:** _____
(Patient, Parent or Authorized Individual)