Advanced Orthopedics and Sports Medicine, LLC
Patient Information

Patient **LEGAL** Name: _____ SS#: _____

Marital Status: S M W D Sep Sex: M F Date of Birth: _____

Address: _____
Street City State ZIP

Phone: (H)_____ (W)_____ (C)_____

Appt Reminder: Voice ( )_____ Text ( )_____ Email None

Email:_____

Employment Status: Employed Unemployed Retired Student

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Race: White Black/African American Hispanic Asian American Indian/Alaskan Native Middle Eastern
Native Hawaiian/Other Pacific Islander Other:_____ Decline to answer

Pharmacy Name: _____ Pharmacy #: _____-_____

Person responsible for bill or parent's name (Complete only if different from patient)

Guarantor Name: _____ SS#: _____

Date of Birth: _____ Phone: (H) _____ (W)_____

Address: _____

Primary Insurance: _____

Name on Card: _____

SS# of Person on Card:_____

DOB of Person on Card: _____

Insurance ID#: _____

Insurance Group#: _____

Secondary Insurance: _____

Name on Card: _____

SS# of Person on Card:_____

DOB of Person on Card: _____

Insurance ID#: _____

Insurance Group#: _____

Policy Holder's address if different from patient: _____

Emergency Contact (Relative /friend not currently living with you)

Name: _____ Phone: _____ Relationship: _____

I authorize the release of any medical information necessary to process this bill to my insurance company and request payment of benefits to Advanced Orthopedics of Clayton. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

SIGNATURE: _____ Date: _____

ADVANCED ORTHOPEDICS & Sports Medicine

Patient Name:_____ **Date of Birth.:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

Advanced Orthopedics, LLC reserves the right to modify the privacy practices outlined in the notice.

I have read and/or received a copy of the Notice of Privacy Practices for **Advanced Orthopedics, LLC.**

_____ _____ _____

Signature of Patient/Guardian/Parent | Date | Relationship of Patient Representative to Patient

Authorization to Release Medical Information

I authorize **Advanced Orthopedics, LLC** to disclose medical information, including financial, to the following persons as needed to help with my healthcare, or with payment, for my healthcare:

Name (First and Last)	Phone	Relationship
1.		
2.		
3.		

_____ _____ _____

Signature of Patient/Guardian/Parent | Date | Relationship of Patient Representative to Patient

Inability to Obtain Acknowledgement of Receipt

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on_____.

The acknowledgement was not obtained because:

- ☐ The parent/guardian/patient declined to sign the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgememt
- ☐ Other_____

_____ _____ _____

Signature of AO staff | Printed Name of AO staff | Date

Modified: 09/05/2014

OVER

Advanced Orthopedics of Clayton, LLC

Patient Financial Policy

Thank you for choosing our practice. We are committed to the success of your medical care. Please understand that payment of your bill is part of this care. To help avoid misunderstandings, our financial policy is in writing. For your convenience, we have answered some commonly asked questions below. If you have further questions, please contact our billing department at 314-721-7325.

How may I pay?
We accept payment by cash, check or credit card (VISA, Mastercard and Discover Card).

What if my child needs to see the physician?
A parent or legal guardian must accompany all patients who are minors on the patient's first visit, and must sign the financial statement for the patient, accepting responsibility for the account.

What is your policy regarding missed appointments?
If you are unable to keep your scheduled appointment, please call our office within 24 hours to reschedule your appointment. This will enable us time to use your slot for another patient. Patients who do not show up for an appointment, and do not call to cancel have impacted other patient's ability to obtain timely medical care. Therefore, subject to the individual patient's insurance contract, we reserve the right to charge for missed appointments.

Do co-pays need to be paid at the time of my appointment?
Yes. According to your contract with your insurance company, all co-pays are to be paid at the time of service. Refusal to abide by this agreement may result in an additional billing charge (to cover the cost of having to bill you for the co-pay) and/or termination of your coverage.

How am I to pay my portion after you bill the insurance?
Please bring your insurance card with you at the time of your appointment. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. **The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier.**

You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Once we receive the Explanation of Benefits from your insurance company, we will bill you for the balance that you owe. That amount is due upon receipt of the statement.

What if I don't have insurance?
Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our Office Coordinator or Practice Manager.

What if I need to see the doctor for a work-related injury?
If your injury is due to an accident in your work place, please be sure to contact your employer and inform them of your injury. We will need to receive authorization from your employer before we can process any of your medical claims. Please have your employer contact our office. Failure to properly report this injury to your employer may result in your claims being denied. Denied claims will be your responsibility.

What if my check bounces?
If a check is returned for insufficient funds, or if payment has been stopped, you will be charged a $35 fee in addition to the amount of the check. If you have a second check returned, you may be asked to pay by cash, money order or cashier's check or credit card.

What if I do not pay my bill?
Accounts that are repeatedly ignored may be sent to collections. If this happens, you may have your credit adversely affected, and you will be dismissed from the practice and asked to find a new physician.

Are there other fees I may anticipate?
There will be additional charges for the completion of medical forms, copies of medical records and x-rays. These charges may vary. Payment is due before or at the time you pick-up the forms and/or records. If you would like them mailed to you or your insurance company, there may be an associated fee to cover mailing costs. There will be possibly be additional charges for some services/products we offer such as, braces, slings, heel pads, waterproof casting, other durable medical equipment, ultrasound guided injections, and platelet rich plasma injections.

Acknowledgement
I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance, as well as applicable co-pays and deductibles, are my responsibility. I authorize insurance benefits be paid directly to Advanced Orthopedics of Clayton LLC, and I authorize them to release any pertinent medical information to facilitate payment of a claim. *I have received* a copy of this policy.

Date	Signature of Responsible Party	Printed Name	Patient Name (if different)

DISCLOSURE OF PHYSICIAN OWNERSHIP

NOTICE TO PATIENTS

Please carefully review the information contained in the is notice.

1. At some point during the course of your treatment with your physician, Jason Young, M.D. or Jason Browdy, M.D., you may be referred to Emerson Road Surgery Center, North Campus Surgery Center, and/or Emerson Road Imaging Center to receive treatment and/or services.

2. Jason Young, M.D. and Jason Browdy, M.D. are owners of Emerson Road Surgery Center, North Campus Surgery Center and Emerson Road Imaging Center.

3. You have the right to choose the provider of your healthcare services and the facility where you receive services or treatment. Therefore, you have the option to use facilities other than Emerson Road Surgery Center, North Campus Surgery Center and Emerson Road Imaging Center.

4. You will not be treated differently by Dr. Young or Dr. Browdy if you choose to obtain healthcare services at a facility other than Emerson Road Surgery Center, North Campus Surgery Center or Emerson Road Imaging Center; however please be advised that if you choose to receive services at another facility, Dr. Young and/or Dr. Browdy will be required to hold privileges at such facility in order to treat you at such facility.

If you have any questions concerning this notice, please feel free to ask Dr. Young, Dr. Browdy or any member of our staff. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Emerson Road Surgery Center and Emerson Road Imaging Center.

_____	_____
Signature of Patient	Signature of Parent or Guardian (if applicable)
_____	_____
Print Name of Patient	Print Name of Parent or Guardian (if applicable)
_____	
Date	