Arlington Orthopedics and Hand Surgery Specialists, LTD.

M. Bryan Neal, M.D.

PATIENT INFORMATION

Patient Name: ______________________ Date of Birth: ____-____-____ Sex: ______

Dependent? ☐ Yes ☐ No If yes, Guardian's Name: ______________________

Driver's License #: ______________________ Social Security #: ______-______-______

Home Phone #: (______)______-______ Cell #: (______)______-______

May we leave a detailed message on voicemail? ☐ Yes ☐ No Marital Status: ☐ S ☐ M ☐ D ☐ W

Street Address: ______________________ City: ______________ State: ____ Zip: ______

Employer: ______________________ Work Phone #: (______)______-______

Employer Address: ______________________ City: ______________ State: ____ Zip: ______

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: ______________________ Relationship: ______________

Home Phone #: (______)______-______ Cell #: (______)______-______

2nd Emergency Contact Name: ______________________ Relationship: ______________

Home Phone #: (______)______-______ Cell #: (______)______-______

INSURANCE INFORMATION

Insured Party: ______________________ Relationship to Patient: ______________

Insurance Company: ______________________ Phone #: (______)______-______

Address: ____

Policy #: ______________ Group #: ______________ Date of Birth of Insured: ____-____-____

Dual Coverage?: ______ 2nd Insurance Company: ______________________

Insured Party: ______________________ Relationship to Patient: ______________

Address: ____

Policy #: ______________ Group #: ______________ Date of Birth of Insured: ____-____-____

Payment Method: ☐ Cash ☐ Check ☐ Credit Card

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-Rays, photographs, anesthetics, medicines, surgeries and other equipment or aids as he deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance and/or copay is due at the time of service. I authorize this office to apply benefits on my behalf for the covered services rendered.

Print Name of Patient or Legal Guardian: ______________________________

______________________________ ______-______-______

Signature of Patient or Legal Guardian Date

Arlington Orthopedics and Hand Surgery Specialists, LTD.

M. Bryan Neal, M.D.

MEDICAL HISTORY FORM

Patient Name: ______________________ **Date of birth:** ____ - ____ - ____ **Weight:** ______ **Height:** ______ **Age:** ______

Reason for visit: ____

____

If Injured, Date of Injury: ________ - ________ - ________

Past Medical History/Review of Systems

Please check (X) the box next to any illnesses or problems that may apply to you.

☐ Cancer ☐ Asthma ☐ Tuberculosis/HIV ☐ Liver Disorder ☐ Diabetes
☐ Alcoholism ☐ Heart Disease ☐ Emphysema/COPD ☐ Birth Defects ☐ Heart Attack
☐ Ulcers ☐ Kidney Disease ☐ High Blood Pressure ☐ Stroke ☐ Gout
☐ Cholesterol ☐ Sickle Cell Anemia ☐ Bleeding Disorder ☐ Arthritis

Please Explain: ____

____

____

Are you or could you be pregnant? ☐ Yes ☐ No

Surgery/Fractures

Please check (X) the box to any surgical procedures which you have had.

☐ Tonsils ☐ Breast ☐ Appendix ☐ Uterus ☐ Gallbladder
☐ Ovaries ☐ Stomach ☐ Prostate ☐ Small Intestine ☐ Colon
☐ Thyroid ☐ Kidney ☐ Hernia (repair) ☐ Heart ☐ Pacemaker
☐ Joint Replacement ☐ Arthroscopy

☐ Extremities, Neck, Back (What kind): ______________________________

☐ Any other surgeries (What kind): ______________________________

Allergies:

____
____
____
____

Medications:

____
____
____
____

Do you have any of the following conditions?

☐ Shortness of breath ☐ Chest Pain ☐ Blurred Vision ☐ Frequent/Painful Urination
☐ Unexpected Weight Loss ☐ Fever/Chills ☐ Headaches ☐ Numbness in Extremities
☐ Constipation/Diarrhea/Blood in Stools

Tobacco Use

☐ Cigarettes: Yes/No Packs/day__________Years of use__________

☐ Other tobacco use: ______________________________

Alcohol Use

☐ Beer/Wine: ______________________ X a week

☐ Shots/Liquor: ______________________ X a week

☐ Other drug use: ______________________

Family History Please check (X) the box next to any disease diagnosed in your blood relatives.

☐ Cancer ☐ Diabetes ☐ Rheumatoid Arthritis ☐ Other type of arthritis ☐ Gout
☐ Bleeding Problems ☐ Sickle Cell Anemia ☐ Heart Disease

☐ Other: ____

Who is your primary care physician? ______________________________

Physician Phone Number: (______) ______________________

______________________________ Signature of Patient or Legal Guardian

______ - ______ - ______ Date

Arlington Orthopedics and Hand Surgery Specialists, LTD.

M. Bryan Neal, M.D.

INSURANCE AND OFFICE POLICY

Arlington Orthopedics and Hand Surgery Specialists, LTD. believes that in the interest of good healthcare practices, it is best to establish a patient account policy between our patients and ourselves up front in order to avoid any misunderstandings. Our billing representatives will be glad to discuss your account with you at any time. Our primary responsibility is to deliver quality healthcare services. We expect you to show us the same consideration, and to be honest and forthright regarding your financial responsibility.

1. **Payment in Full** - Payment is required at the time of your visit. We accept cash, Check, Discover, Visa or MasterCard.
2. **Insurance Claims** - We will file a claim to your insurance for the services rendered. It is your responsibility to make sure your insurance is effective. You will be responsible for any co-insurance and deductibles after we have filed your insurance. If for any reason your insurance company does, not pay, or pay as expected, you will be responsible to pay the remaining balance. Please remember that insurance coverage is a contract between the patient and the insurance company.
3. **Surgical Claims** - You will be held responsible for any services not covered under your insurance policy. When payment has been received from your insurance company, if a balance remains, a statement will be sent to you for payment within 30 days.
4. **Third Party Responsibilities** - WE DO NOT FILE TO THIRD PARTIES OR TO ANY MOTOR VEHICLE INSURANCE.
5. **Returned Checks** - A service charge of $ 50.00 will be applied to all returned checks. We require any returned checks and fees to be cleared prior to being seen by your physician at Arlington Orthopedics and Hand Surgery Specialists, LTD. We accept only cash or credit card (Discover, Visa or MasterCard).
6. **Stop Payments** - If a payment or prepayment for a procedure is stopped, all applicable charges and stop payment fees will be applied to the patient's bill. We accept only cash or credit card (Discover, Visa or MasterCard). If a procedure gets cancelled and there was a prepayment for the procedure, please inform the office so a refund can be issued instead of doing a stop payment.
7. **Prior balances on Account** - All balances for services rendered will be collected before each appointment.
8. **Divorced Parents** - It is the policy of this office that the parent accompanying the child to the visit will be held responsible for all charges incurred regardless of the insurance or financial situation. **ARLINGTON ORTHOPEDICS AND HAND SURGERY SPECIALISTS, LTD** WILL NOT BILL OR DISCUSS TREATMENT WITH THE OTHER PARENT UNLESS AUTHORIZATION IS ON FILE.

I have read and understand the financial policy for ARLINGTON ORTHOPEDICS AND HAND SURGERY SPECIALISTS, LTD.

Printed name of the patient: ______________________________

Patient's Signature: ______________________________ Date: ______/______/______

If patient is a minor, then parent or legal guardian please sign below:

Printed name of parent/legal guardian: ______________________________

Signature of parent/legal guardian: ______________________________

Arlington Orthopedics and Hand Surgery Specialists, LTD.

M. Bryan Neal, M.D.

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask our billing department if you have any questions about fees or Financial Policy.

* All patients must complete our "Patient Information Form"
* WE ACCEPT CASH, CHECK, VISA, MASTERCARD AND DISCOVER.

MEDICARE

We accept Medicare assignment. As a Medicare patient you are responsible only for the difference between the approved charge and the amount Medicare pays. If you have a supplemental insurance we will bill them directly for you. You will receive a bill after the insurance has paid.

HMO/PPO

WE DO NOT CONTRACT WITH ANY HMO/PPO INSURANCE COMPANIES. WE WILL FILE ALL CLAIMS FOR YOU BUT IT IS YOUR RESPONSIBILITY FOR ALL BALANCES OWED.

WORKERS' COMPENSATION

Patients being seen as a result of a work related injury are still responsible for charges incurred by them. At the time of your visit, we will attempt to verify coverage of your charges by your employer. If we cannot verify coverage, we will bill you directly for your charges. Also, if your employer does not pay for your charges within a reasonable period of time, we will bill you directly.

LEGAL OR ACCIDENT CLAIMS

If you are here as a result of an accident claim, we require payment at the time of service.

FILING INSURANCE CLAIMS

In order to file a claim on behalf of the patient, we must have a copy of the insurance I.D. card and the complete address of where the claim is to be sent. Without this information, you will be billed directly. We file claims for Medicare, HMO/PPO's, Workman's Comp and surgical charges.

PRIVATE PAY

Dr. Neal does make arrangements on individual cases.

No Show/Late Cancellation Policy

This Policy has been established to better serve you as well as all patients. When an appointment is made it removes the ability for other patients to be seen efficiently as possible. No-Shows and late cancellations cause a delay in delivery of health care to other patients.

A "No Show" is missing a scheduled appointment without prior notice. A "Late Cancellation" is canceling an appointment without calling 24 hours in advance of an office visit or 48 hours in advance of a procedure.

A charge of $25.00 may be assessed for each No Show or Late Cancellation less than 24 hours prior to appointment.

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be addressed on a case-by-case basis.

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

____   ____________________

Signature of Patient or Legal Guardian   Date

PLEASE TURN OVER

Arlington Orthopedics and Hand Surgery Specialists, LTD.

M. Bryan Neal, M.D.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATIONS

I,____, hereby acknowledge receipt of Arlington Orthopedics and Hand Surgery Specialists, LTD. Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available upon my request.

With my consent, Arlington Orthopedics and Hand Surgery Specialists, LTD. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out **T**reatment, **P**ayment and healthcare **O**perations (**TPO**), such as a missed appointment, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Arlington Orthopedics and Hand Surgery Specialists, LTD. may mail to my home or other designated location any items that assist the practice in carrying out **TPO**, such as missed appointment letters and patient statements.

With my consent, Arlington Orthopedics and Hand Surgery Specialists, LTD. may transmit my medical records via fax machine to assist the practice in carrying out **TPO**.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior request. If I do not sign this consent, Arlington Orthopedics and Hand Surgery Specialists, LTD. may decline to provide treatment to me.

____

Print Name of Patient or Legal Guardian

____

Signature of Patient or Legal Guardian **Date**

POS Reorder # 1617062