

Charles J. DePaolo, M.D., P.A.

3B McDowell Street, Asheville, NC 28801 • Phone 828-225-1920 • Fax 828-225-1924

Account # _____ Appt. Date: _____ Appt. Time: _____

PATIENT INFORMATION

Patient SSN: _____ Pharmacy Preference and location: _____

Patient Name: _____

Patient Address: _____
(Street Address) (City, State, Zip Code)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: Male Female Birth date: _____ Marital Status: S M D W

Patient's Employers: _____ Work Phone: _____

Employer Address: _____
(Street Address) (City, State, Zip Code)

Referring Doctor: _____ Primary Care Doctor: _____

Guarantor Name: _____ Guarantor Phone: _____

Guarantor Address: _____
(Street Address) (City, State, Zip Code)

IS THIS APPOINTMENT IN RESPONSE TO A WORK-RELATED INJURY? _____

If NO, please complete the insurance information below. If YES, please notify the front desk and you will be given a form to complete.

IS THIS RELATED TO A MOTOR VEHICLE ACCIDENT OR THIRD PARTY INJURY? _____

INSURANCE INFORMATION

PRIMARY Insurance Company: _____

Insurance Address: _____
(Street Address) (City, State, Zip Code)

Subscriber's Name: _____ Subscriber's Sex: Male Female

Subscriber's SSN: _____ Subscriber's Birth date: _____

Relationship to Patient: self spouse parent

Subscriber's Employer: _____ ID Number: _____ Group Number: _____

SECONDARY Insurance Company: _____

Insurance Address: _____
(Street Address) (City, State, Zip Code)

Subscriber's Name: _____ Subscriber's Sex: Male Female

Subscriber's SSN: _____ Subscriber's Birth date: _____

Relationship to Patient: self spouse parent

subscriber's Employer: _____ ID Number: _____ Group Number: _____

CONSENT SECTION:

I consent to medical treatment and procedures by Charles J. DePaolo, MD, PA and his staff and have read and agree to the policy sheet included in the new patient package. I am responsible for all charges incurred at Charles J. DePaolo, MD, PA and authorize payment of insurance benefits (Medicare, Medicaid, or commercial insurance) directly to this practice. I authorize the release and transmission of pertinent medical information for research purposes and/ or medical information necessary to determine insurance benefits. I am responsible for payment of all charges not covered by insurance contracts, including co-payments, deductibles, non-covered services, and those determined by the insurance company, where there is no contract with Charles J. DePaolo, MD, PA to be above their usual and customary.

Authorization for the Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. Please the family members or other persons, if any, whom we may inform about your appointments, labs, x-ray results and/ or other healthcare information. **PLEASE NOTE THAT THE FIRST PERSON LISTED SHOULD ALSO BE YOUR EMERGENCY CONTACT.**

NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

Can confidential messages including appointment reminders, labs, x-ray results, and/ or other health care information be left on your home answering machine or voicemail? (PLEASE CHECK ONE) YES NO

IF NO, PLEASE PRINT THE TELEPHONE NUMBER, IF ANY, WHERE YOU WANT TO RECEIVE THIS INFORMATION: _____

I understand that I may revoke or change this authorization at any time by notifying the office of Charles J. DePaolo, MD, PA in writing. I understand and agree that Charles J. DePaolo, MD, PA has THIRTY (30) days from the receipt of the written revocation to update this information in the system.

However, the revocation will not be valid if:

1. Charles J. DePaolo, MD, PA has taken action in reliance on the above authorization.
2. This authorization is obtained as a condition for obtaining insurance coverage. Other laws provide the insurer with the right to contest a claim under the policy or the policy itself.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I have received a copy of the Notice of Privacy Practice for the above named practice. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by writing to the Privacy Officer, 3B McDowell Street, Asheville, NC 28801 or by requesting one in person at the office located at the same address.

Patient Signature: _____

Date Signed: _____

Today's Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____

How did you hear about us? Circle one.

Phone Book Ad M.D.

Other: _____

Referring Physician: _____

Family Physician: _____

CHIEF COMPLAINT: (description of your current orthopedic problem): _____

DATE OF INJURY/ONSET OF PAIN: _____

HISTORY OF PRESENT ILLNESS: (please answer these questions regarding your current problem)

Where? RIGHT or LEFT? What are your symptoms? How long have you had these symptoms?

PAST MEDICAL HISTORY: (ALSO LIST ANY MEDICAL CONDITIONS FOR WHICH YOU ARE CURRENTLY BEING TREATED, INCLUDING PREVIOUS HOSPITALIZATIONS.) _____

Have you ever had the following type of "BLOOD CLOT"

DEEP VEIN THROMBOSIS (DVT): YES / NO DATE: _____ PULMONARY EMBOLISM: YES / NO DATE: _____

Surgical History (TYPE OF AND DATE): _____

Current Medications (PLEASE LIST DOSAGE, FREQUENCY, AND CONDITION BEING TREATED): _____

Any Known Allergies (TO MEDICATIONS): _____

FAMILY MEDICAL HISTORY (PAST OR CURRENT MEDICAL CONDITION OF FAMILY MEMBER):

Mother: _____

Father: _____

Siblings: _____

SOCIAL HISTORY (PLEASE CIRCLE OR COMPLETE ALL THAT APPLY):

Single Married Widowed Divorced/Separated

Spouse's Name: _____

Tobacco use (packs per day): _____ Alcohol use (drinks per day): _____

REVIEW OF SYSTEMS (PLEASE CIRCLE ALL THAT APPLY):

Constitutional

Fever
Weight Change

Eyes

Visual Changes
Glaucoma

Ear, Nose & Mouth

Hearing Change
Sinus Problems
Dental Problems

Cardiovascular

Heart Failure
Chest Pain
Blood Pressure

Respiratory

Asthma
Difficulty Breathing
Tuberculosis
Pneumonia

Endocrine

Diabetes
Thyroid Problems

Gastrointestinal

Nausea/ Vomiting
Blood in Stool

Genitourinary

Urinary Infections
Incontinence

Skin

Infections
Lesions/ Ulcers

Neurological

Seizures
Strokes
Paralysis

Psychiatric

Depression
Anxiety

Hematologic

Anemia
Bleeding Disorders

VITALS

Weight: _____

Temperature: _____

Pulse Rate: _____

Respiration: _____

Oximetry: _____

BP: _____

PATIENT Signature: _____

Date: _____

Physician Signature: _____

Date: _____

DR. CHARLES J. DEPAOLO, MD, PA

NOTICE OF PRIVACY PRACTICES

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

OUR LEGAL DUTY

The privacy of your medical information is important to us. We are required by federal and state law to protect the privacy of your medical information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect June 1, 2005, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all medical information that we maintain, including medical information we created or received before we made the change. Before we make a significant change in our privacy practices we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose medical information about you for treatment, payment, and healthcare operations.

Treatment: We may use or disclose your medical information to a physician or other healthcare providers involved in your care including your referring physician, or provider and other physicians or providers consulted in your care, or to whom you may be referred, including physicians, providers, and healthcare facilities such as a hospital or medical laboratory.

Payment: We may use and disclose your medical information to receive payment for services provided to you.

Healthcare Operations: We may use and disclose your healthcare information during normal healthcare operations. Healthcare operations include such things as quality assessment and improvement, training programs, accreditation, certification, licensing and/or credentialing of our physicians, providers, and facilities.

Your Authorization: In addition to our use of your medical information for treatment, payment, and healthcare operations you may give us written authorization to use or disclose your healthcare information to anyone for any purpose. This authorization may be revoked by you, in writing, at any time but will not affect any use or disclosure of medical information during the time the authorization was in effect. Without written authorization we cannot use or disclose your medical information for any reason not covered in this Notice.

Persons Involved in Your Care: We may use or disclose your medical information to notify a family member, your personal representative or another person responsible for your care, of your location and your general condition. If you are present we will provide you an opportunity to object to such use or disclosure. In the case of an emergency, or if you are incapacitated for any reason, we will use our professional judgment in determining if such use or disclosure is necessary and in your best interest. We will also use our professional judgment in allowing a person, other than you, to pick up prescriptions, medical supplies, or other similar forms of healthcare information or material.

Appointment Reminders: We may use or disclose your medical information to provide you with appointment reminders including answering machine messages, post cards, or mailings unless you specifically object to receiving these reminders in writing.

Abuse or Neglect: We may use or disclose your medical information to appropriate authorities if we reasonably believe you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your medical information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Required by Law: We may use or disclose your medical information in certain circumstances when we are required to do so by state or federal law. If you are a member of the Armed Forces we may disclose your medical information to military authorities. We may disclose medical information to correctional institutions or law enforcement representatives if you are in their lawful custody.

PATIENT RIGHTS

Access: You have the right to look at or get a copy of your medical information if requested in writing. We will charge you a reasonable, cost-based fee for expenses such as photocopies and staff time. We will charge \$0.20 per

page for photocopies and \$15 per hour for staff time to locate and copy your medical information, and postage if you want the copies mailed to you. Once we receive a request for review we will estimate the cost and provide that to you.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, healthcare operations, or those specifically authorized by you within the last six years, but not prior to June 1, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree with these additional restrictions, but if we do, we will abide by our agreement.

Confidential Communications: You have the right to request that we communicate with you about confidential medical information by alternative means or to an alternate location. The request must be made in writing and specify the nature of the alternative means or the alternate locations and provide a satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your medical information. Your request must be made in writing and it must state the information to be amended and explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns please contact us.

If you are concerned that we may have violated your privacy rights or if you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may complain to us at the time of the incident or you may use the contact information listed at the end of this Notice.

You may also submit a written complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to privacy for your medical information and will not retaliate in any way if you choose to file a complaint with us, or with the U.S. Department of Health and Human Services.

Privacy Officer: **Lisa Wheeler**

Telephone: **828-225-1920**

Fax: **828-225-1924**

Address: **Charles J. DePaolo, MD, PA**

3B McDowell Street

Asheville, NC 28801

I have read and acknowledge receipt of Notice of Privacy Practices for Dr. Charles J. DePaolo.

Patient Name

Patient or Legal Representative Signature

Relationship to Patient

Date



Charles J. DePaolo, M.D., P.A.

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www.CDePaoloOrtho.com

Patient Name: _____

MR # (office): _____

Thanks for choosing Dr. DePaolo and his staff for your orthopedic needs. We are very interested to know how you heard about us. Please feel free to choose one or more of the following if applicable.

___ FAMILY MEMBER (NAME: _____)

___ FRIEND (NAME: _____)

___ CO-WORKER (NAME _____)

___ RADIO OR OTHER MEDIA

___ PHONE BOOK

___ INTERNET

___ PHYSICIAN OR OTHER MEDICAL PROFESSIONAL
(NAME: _____)

___ PRINT MEDIA OR ADVERTISING

___ WORKER'S COMP OR LEGAL REPRESENTATION
(NAME: _____)

___ WORKER'S COMP NURSE (NAME _____)

___ URGENT CARE CENTER (NAME: _____)

___ OTHER _____

Welcome to Charles J. DePaolo, MD, PA. We are committed to providing you with quality and affordable health care. Please understand that payment of your bill is part of this treatment and care. Read these policies and feel free to ask us any questions you may have.

Financial Responsibility:

It is important for you to understand that you, the patient, are ultimately responsible for payment of medical services you have received. Cash, personal check or credit card are accepted methods of payment.

Proof of Insurance:

All patients must complete our patient information form. We must obtain a copy of your driver's license and current, valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information at each visit you may be responsible for the balance of a claim.

Non-Contracted or Commercial Plans:

If you are not insured by a plan we are contracted with, payment in full is expected at each visit. We will prepare and send a claim as a courtesy for you. Knowing your insurance benefits and which medical providers are found in your insurance network is your responsibility. All out of network charges are your responsibility at the time of service. Please contact your employer or insurance company with any questions you may have regarding your coverage.

Network or Contracted Plans:

We participate in many insurance plans. If you are insured by a plan we are contracted with, you will be billed according to guidelines established by the insurance company. If you are insured by a plan we are contracted with, but do not have an up-to-date insurance card or are unable to provide proof of insurance, payment in full for each visit is required until we can verify your coverage.

Co-payments and Deductibles:

All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered a breach of contract. Co-payments will be collected at patient check-in.

Non-Covered Services:

Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered "reasonable" or "necessary" by your insurer. Keep in mind that a medical necessity is not the same as a medical benefit. A medical necessity is something that your doctor has decided is necessary as part of your medical treatment. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your medical provider might decide that you need medical care that is not covered by your insurance policy. Insurance companies determine what tests, drugs and services they will cover as part of an individual plan. These choices are based on their understanding of the kinds of medical care that most patients need. Your insurance company's choices may mean that the test, drug or service you need isn't covered by your policy. While our office may be aware that these restrictions could exist, our patients represent thousands of insurers with as many benefit plans. Unfortunately, we will not be able to know for certain if your insurer will "cover" your services. However, if, in our opinion, the service you are receiving may not be covered, you will be asked to pay at the time of service. It is your responsibility to understand the terms of your individual insurance plan and the services which are covered, are not covered and have limited coverage. You may be responsible for payment of any services considered non-covered by your insurance plan.

Claims Submission:

We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. We will make every attempt to receive proper payment from your insurance company for services provided. If, however, we are unable to get a satisfactory response from your insurance company within 60 days, the balance will become your responsibility.

Uninsured:

Patients not covered by health insurance are expected to pay in full at each visit without exception. New patients to our practice will be asked for a \$150.00 deposit at the time of check-in to be applied toward their first visit. Uninsured patients are eligible for a prompt pay discount (see below).

Statements:

Statements are mailed on a monthly cycle. Payment in full is due within 25 days. Accounts with balances remaining after receiving two (2) statements are considered overdue. If your account is 60 days past due, you will receive a letter stating you have 15 days to pay your account in full. You may receive a second letter if the balance remains unpaid. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. When an account is referred to a collection agency the agency fee will be added to the outstanding balance. The agency fee is 25% of the outstanding balance.

Past Due Balance:

Any balance more than 60 days old will be considered past due. Once a balance is past due, payment will be required before your next visit in the office. We ask that you please make a payment over the telephone when scheduling your appointment. Or, you can make a payment at the time of service before you are seen for your next visit. Failure to make payment on a past due balance before your next scheduled appointment will result in the cancellation of your appointment and you will need to reschedule once payment is made.

Prompt-pay Discount:

Our office offers a prompt pay discount to patients who pay in full at the time of service. Please ask our Front Office staff about this program.

Returned Check:

Checks written at the time of your visit or mailed as payment on an account balance that are returned by the bank will be assessed a \$20.00 Returned Check Charge. If the original check amount plus the Returned Check Charge is not paid within 15 days your account will be considered for transfer to the collection agency.

Completion of Forms:

The "Patient" section of any form must be completed before we can accept your form. Any form or letter request must be allowed 10 business days for completion, pending the doctor's availability for signature. Fees: \$25 for any form greater than one page. One page forms are \$10. All form completion fees must be paid in full before the forms are returned to you or forwarded on your behalf. Please ask our Front Office staff about fees associated with different forms.