

Susquehanna Orthopaedic Associates

PATIENT REGISTRATION

☐ New Patient ☐ Established Patient ☐ New Injury ☐ Work Comp ☐ Auto

Patient Name _____ Birth Date (MM/DD/YY) _____

Home Phone _____ Cell Phone _____ Patient Email _____

Patient Address (Street, City, State, Zip) _____ Patient's Social Security # _____

Patient's Employer _____ Work Phone _____ Occupation _____

Insurance Name _____ Member ID _____ Group # _____

Insurance Address (Street, City, State, Zip) _____ Insurance Phone _____

Policy Holder's Name (Person Financially Responsible for Insurance) _____ Birth Date (MM/DD/YY) _____ Social Security # _____

Policy Holder's Employer _____ Relationship to insured _____

Secondary Insurance Name _____ Member ID _____ Group # _____

Secondary Insurance Address (Street, City, State, Zip) _____ Secondary Insurance Phone _____

Policy Holder's Name (Person Financially Responsible for Secondary Ins.) _____ Birth Date (MM/DD/YY) _____ Relationship to Insured _____

Primary Care Physician Name _____ Physician Phone _____

Primary Care Physician Address (Street, City, State, Zip) _____

Person to Contact in Case of Emergency _____ Relationship to Patient _____ Contact Phone _____

Workers' Compensation? ☐ Yes ☐ No

Motor Vehicle Injury? ☐ Yes ☐ No

Date of Injury (MM/DD/YY)

Treatment Authorized By (Case Manager's Name)

Case Manager Phone

Primary insurance Name

Claim Number

Insurance Phone

Primary Insurance Address (Street, City, State, Zip)

Insurance through Your Employer? ☐ Yes ☐ No

I hereby acknowledge the above information is true and correct to the best of my knowledge.

Patient, Parent or Guardian Signature (if Child is Under 18 Years Old)

Date (MM/DD/YY)

Susquehanna Orthopaedic Associates

PATIENT CONSENT FORM

Patient Name _____

Birth Date (MM/DD/YY) _____

Please review each paragraph below and sign where indicated

CONSENT TO TREAT

I request consent and authorize the administration and performance of all treatments and diagnostic procedures, including, but not limited to; x-rays, laboratory test, which in the judgment of the providers involved in my care are considered necessary or advisable.

INFORMATION RELEASE

I authorize the release of any medical information necessary to process claims for payment and to those entities to which I may be referred for care, continuity of care or for further testing. Susquehanna Orthopaedic Associates and its employees are hereby released from all liability of any nature that may arise from the release of such information.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment to be made directly to Susquehanna Orthopaedic Associates for surgical and/or medical benefits. In the event that I directly receive any proceeds from my insurance and my account balance is unpaid I agree to pay Susquehanna Orthopaedic Associates within 20 days of the first statement. If my medical insurance or workmen's compensation, insurance plan or auto/liability claim is not verifiable or denied, I agree to pay for all services as presented. If I do not have proper billing information at the time of my visit, I agree to pay for those services at the time of the visit. If surgery is needed, I am aware that my insurance company may require me to pay a 20% coinsurance, and or deductible. I am aware that if payment in full is not received within those 90 days, my account will be sent to collections. I understand that I am personally responsible for and guarantee the payment for all costs of treatment and services rendered. I further agree that if payment in full is not paid when due, I agree to be responsible for and pay a **finance charge** of one and one-half percent **(1.5%)** per month **(18% per annum)**, all costs of collection and Attorney fees at the agreed rate of 33% of the total outstanding balance then due. In the event this matter is filed with the courts, I consent to the personal jurisdiction and venue of the courts of Harford County, Maryland and ***I waive all rights to have this matter tried before a jury.***

By signing below, I acknowledge that I have read and agree with the terms and conditions noted above.

_____, SEAL
Patient's Signature, or Patient's Representative

Date (MM/DD/YY)



John P. O'Hearn, M.D.
Susquehanna Orthopaedic Associates
2 Colgate Dr, Suite 204
Forest Hill, MD 21050

CANCELLATION / MISSED APPOINTMENT POLICY

Your appointment is very important to Dr. O'Hearn and it is reserved especially for you. We understand that sometimes patients are unable to keep a scheduled appointment due to unforeseen circumstances; however, we require at least 48 business hours' notice for cancellations.

When you forget or cancel your appointment it prevents us from giving you the care you need and it prevents us from filling the appointment time and other patients miss the opportunity to be seen by the doctor.

Our appointments are confirmed in advance because we realize it is easy to forget an appointment you made weeks or months ago. Since the time is reserved for you personally a cancellation fee of \$50.00 will apply. This fee is not covered by insurance and will be due to us promptly upon receipt of your bill.

Thanks for your understanding.

Patient Signature

Date (MM/DD/YY)

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Susquehanna Orthopaedic Associates Notice of Privacy Practices. By signing below, I am only giving acknowledgment that I have received or have had the opportunity to receive the Notice of Privacy Practices. (Copies are available on our website www.soaortho.com or in the waiting room at the Forest Hill office).

I am aware that Dr. John O'Hearn MD, Susquehanna Orthopaedic Associates, participates in the Chesapeake Regional health information exchange and that all patients are automatically included in this unless specifically opting out in writing.

Patient Name

Patient Signature