David R. Gotham, Jr., D.O. INC.
Comprehensive Orthopaedic Care

Name: _____ Age _____

Address: _____ Social Security (Last 4) _____

City: _____ State: _____ Zip; _____

Email: _____

Home Phone: _____ Message Phone; _____

DOB_____ Male/Female _____ Marital Status _____

Occupation: _____ Name of Employer _____

Primary Care Physician _____ Date of Injury _____

INSURED INFORMATION

NAME _____Relationship to patient_____

Address _____ City _____ State _____ Zip _____

DOB_____ SSN _____

Employer _____ Phone_____

PRIMARY INSURANCE _____**SECONDARY INSURANCE** _____

CARRIER: _____ CARRIER: _____

ID _____ID_____

SUBSCRIBER_____SUBSCRIBER_____

I hereby authorize David R Gotham Jr, DO, Inc and affiliate billing companies to furnish information to insurance carriers regarding my treatment. I hereby assign to the physician all payments for medical services. I request payment be made directly to the treating physician. **Insurance provided must be active and current at the time of all treatments or surgeries.** Furthermore, I understand that I am responsible for any amount not covered by the insurance company.

X_____ X_____

Signature of Insurance/Authorized Person Date

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NAME: _____ DATE: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

Reason for visit (including, cause of injury, date or injury, and treatment rendered):

_____

_____

PAST MEDICAL HISTORY (inc. Diabetes, Hypertension, Heart Disease, etc.)

Medical Problems: _____

_____

_____

Previous Surgery: _____

_____

_____

Current Medications: _____

_____

_____

Allergies to Medications: _____

_____

SOCIAL HISTORY:

People in Household & Relationships: _____

Type of Work: _____

Smoking History: _____ If yes, how much per day & how long: _____

Alcohol History: _____

Illicit Drug History: _____

FAMILY HISTORY:

PRESENT HEALTH AND AGE IF LIVING OR CAUSE OF DEATH AND AGE

FATHER: _____

MOTHER: _____

SIBLINGS: _____

CHILDREN: _____

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FINANCIAL POLICY

CASH: Payment-in-full is due at the time services are rendered. We accept cash, checks, and credit cards. If you wish to convert to insurance billing, please refer to the insurance section below and notify our office immediately.

INSURANCE: Co-payments are due at the time of each visit. If co-payment is not made, you will be billed. The bill will include a $10.00 **(initials _____)** billing fee per statement. We must have signed consent from you with the assignment of payments to the office to file claims for you.

ALL PATIENTS: You are ultimately responsible for all charges regardless of any existing medical coverage, and this office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

Upon discharge from the office, all charges are due and payable within 30 days. A charge of $35 (Late Fee) is added to all amount over 30 days. All accounts, on reaching 90 days past due, are subject to submission to an outside collections agency if satisfactory payment arrangements have not been made with the billing departments.

You will be charged $25.00 **(initials _____)** for returned check from the bank (for any reason).

CANCELLED APPOINTMENTS: Our office requires 24-hour notice if you are unable to keep your scheduled appointment. If we do not receive a 24-hour notice, you will be charged a cancellation fee of $50.00 **(initials _____).**

If you have any questions or need to make special arrangements for payment, please notify the billing department immediately.

_____ _____

Patient/Responsible Party: Date:

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SUMMARY OF PATIENT AND PHYSICIAN RESPONSIBILITY

We have entered an age of extreme complexity regarding the various insurance policies that each insurance company provides. Because of this, it has become necessary for our office to place the responsibility of understanding the requirements of your insurance policy on you.

Typically, patients settle their bill for services through utilization of insurance coverage or paying with cash or checks at the time of service. As a service to our patients, we will generally submit the bill for service directly to your insurance company. If the insurance coverage cannot be confirmed, receipts will be provided for cash/check payments so that you may submit them directly to the insurance company for reimbursement. A 15% discount is generally given for cash/check payments at the time of service for patients who do not have insurance coverage. If payment cannot be provided at the time service is rendered, full usual and customary charges will apply. And the bill will be sent to you from our billing service. Full payment is expected within 60 days of service.

Insurance coverage for medical services is typically grouped into contracts that utilize networks of physicians and those that do not. It is the patient's responsibility to understand if their insurance coverage utilizes a physicians' network. This does not necessarily mean that your insurance cannot be utilized for your visit, but it may result in a slightly greater expense to you, the patient, compared to utilizing a physician within your insurance network panel. Please settle your accounts by simply signing over the check {i.e., paid to the order of David Gotham D.O.} endorsing it and submitting it to our office.

Some insurance coverage involves a Health Maintenance Organization (HMO) that utilizes a very limited network of specialists and requires "authorization" from a primary care physician before the insurance company will pay for the services of a specialist. Dr. Gotham does not participate in all HMO networks. If authorization is required for a specialist visit, the patient must obtain such authorization before the visit or pay with cash or check at the time of the visit.

Coverage for medical services is provided to many patients through the federal Medicare program. Charges that physicians may apply for services to Medicare patients are tightly controlled by the federal government. Some physicians choose to "participate" in the Medicare program while others do not. Medicare benefits can be utilized for covered services regardless of whether the physician participates in the federal program or not. As a courtesy, our office will bill Medicare for your services. However, the patient will remain responsible for settling the account if Medicare does not pay.

By convention, the insurance company typically utilizes a global period of service for surgical procedures. This means that the initial charge which is applied at the time of the surgical procedure or at the initial visit for a treatment covers all professional services for the next 90 days. In such cases, regular office visits do not result in any additional charges to the patient during this period. Radiographs, casting, and supplies which were utilized during the visit, however, fall outside the global charge and will result in additional charges being applied to your account.

We offer waterproof casing, separate from insurance billing because insurance does not cover it. Therefore, payment is due at the time of service. Depending on length, we charge either $40 or $50.

We realize the impact of medical costs can result in financial hardship for some patients. As such, our billing service will happily discuss terms for settling the account over a more extended period if it is necessary. If you desire to arrange a payment schedule, please contact our office at 916-771-9555

_____ _____

Patient/Responsible Party: Date:

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Consent for Disclosure of Health Information and Acknowledgement of Privacy Notice Information

This practice is obligated under HIPPA to protect the privacy of your PHI (protected health information) and provide you with a notice of its privacy practice. You may request a paper copy of the Privacy Notice if you wish.

I, _____ acknowledge that I have been offered a copy of the Practice's Privacy Notice at my visit today or at a previous visit.

This practice provides appointment reminders and treatment information via telephone and/or mail. Please indicate the acceptable methods that we may use to contact you. If you are not available, this authorizes us to leave a voicemail message.

Please indicate below by placing an (x) in the authorized fields.
_____ Home: answering, machine/voicemail
_____ Cell Phone
_____ Mail
_____ with another person (Emergency Contact)

Name: _____ Phone Number: _____

If you leave a box BLANK, we will assume we CANNOT contact you by this method.

Is there a family member, friend, or person responsible for your care that you would like to have access to any medical information about you from this office? If so, please list them below:

Name:	Relationship:
_____	_____
_____	_____
_____	_____

_____ _____ _____

Signature of patient OR guardian, parents or personal representative | Date: | Relationship

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OR PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this medical practices Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at my first appointment following amendment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

Parent or guardian of minor patient
Guardian or conservator of an incompetent patient
Beneficiary or personal representative of deceased patient

Name of Patient: _____