Cole Clinic, PA
4716 Alliance Blvd.
Pavilion2 Suite 218
Plano, TX 75093

First Name:_____ **M.I.**_____**Last Name:**_____**D.O.B:**_____

Address:_____

City: _____ **State:** _____ **Zip:** _____

(CELL): _____ **(HOME):** _____ **Email:**_____

Social Security #: _____ **Marital Status:** Divorced / Married / Single /Widowed

Primary Care Physician: _____ PHONE: _____

Who may we contact in case of an emergency?

Name: _____Relationship:_____Phone:_____

Guarantor Information (To be completed if patient is a minor)

In our office, the guarantor is the person who brings the minor patient into the office for orthopedic care. The guarantor is also ultimately financially responsible for the patient's care, despite the fact that another party may actually carry the insurance for the child.

Name of Individual bringing patient to appointment: _____

Guarantor Address:_____DOB:_____

Phone Number: _____ Relationship to patient: _____

Insured Individual's Information: (If same as above, please skip)

Individual Insured's Name: _____DOB: _____

Insured's Address: Same as Above OR:_____

Insured Social Security Number: _____ EMPLOYER: _____

CONSENT FOR TREATMENT

I,_____, authorize and request that **Dr. Christopher Hanssen, M.D.** provide a comprehensive orthopedic evaluation, to include treatment and/or diagnostic procedures which now, or during my care as a patient, are advisable.

_____ _____

SIGNATURE OF PATIENT OR GUARANTOR IF PATIENT IS UNDER 18 **DATE**

HIPAA FORM
PERMISSION TO GIVE MEDICAL INFORMATION

I hereby authorize Dr. Christopher Hanssen and the staff of the Cole Clinic to give the following information concerning my health and wellbeing to the following individuals.

INDIVIDUALS WE CAN RELEASE INFO TO	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

ATTORNEY: _____

*The following **CHECKED** items may be given to the above individual.*
(If nothing is checked then no information will be given out to anyone).

□ ALL INFORMATION MAY BE GIVEN OUT.
□ I REQUEST THAT NO ONE GETS MY INFORMATION.

OR CHOOSE FROM THE FOLLOWING

□ APPOINTMENT TIME(S)	**□ PICK UP MEDICAL RECORDS**
□ PROCEDURES AND/OR SURGERIES	**□ MEDICATIONS**
□ RADIOLOGY FILMS/CD ETC.	**□ TEST AND/OR LAB RESULTS**

CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected healthcare information for the purpose of treatment, various activities associated with payment and healthcare operations. Our Notice of Privacy Practices provides more details. If there is not a copy of the Notice with this form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your healthcare information. As stated in our Notice, we reserve the right to change our privacy practices. If we do so, we will issue a revised Notice. Since revisions may apply to your healthcare information, you have a right to receive a copy and can do so by contacting our Privacy Officer at the practice location. You have the right to revoke your consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this consent. You should also understand that if you revoke this consent, we may decline to treat you. You are entitled to a copy of this consent form after you have signed it.

I have read the contents of this consent form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and activities, and healthcare operations.

_____ _____
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COLE CLINIC, PA

Welcome! Please read the following office policies and let us know if you have questions.

1. If you do not have insurance coverage, **payment is expected at the time of service**.
Please be prepared to pay co-payment, at time of service. You will be asked to pay your deductible and co-insurance at the time of your appointment. If you do not have your co-payment, deductible and/or co-insurance, we ask that you reschedule your appointment.

2. We ask that you please contact our office with any address, telephone or insurance changes.

3. We ask that you please schedule separate appointments for each injury or illness.

4. We ask that you please call to cancel or reschedule your appointment 24 hours prior to your appointment. Missed appointments will be billed at **$25.00** per occurrence. As a courtesy to all our patients, you may be asked to reschedule your appointment if you are more than 20 minutes late.

5. If surgery becomes necessary, there may be a surgery deposit required depending upon your insurance plan. Deductibles and/or coinsurance are due and payable prior to any surgical procedure.

6. Your insurance company may require additional information from you in order to process your claim, such as: accident or injury details, other insurance coverage information or student status. In the event that your insurance company holds your claims while requesting information from you, the balance due will become your responsibility until you contact your insurance company and they pay your claim.

7. After your insurance carrier has paid their portion, there may be an amount not covered and a balance due. If so, we will send you a statement. The balance is due within 30 days.

8. If your insurance mistakenly sends you our payment, please forward the check to us immediately. Failure to do so may result in your account being turned over to a collection agency or small claims court.

9. If your insurance plan requires you to have referral, you must bring a copy of the referral with you to your appointment, or have it faxed to our office prior to your appointment.

10. If you need a prescription refilled, contact your pharmacist. The pharmacy will fax your refill request to our office for review. It is your responsibility to call the pharmacy for refills 24 hours prior to running out of the medication. We do not fax new prescriptions. **PAIN MEDICATION WILL NOT BE REFILLED ON WEEKENDS OR HOLIDAYS**. Replacement prescriptions for prescriptions that were lost will be reissued at a charge of $15.00 per prescription.

11. WE DO NOT BILL AUTO INSURANCE OR THIRD-PARTY LIABILITY INSURANCE. Payment will be expected at the time of service.

12. The national Correct Coding Initiative guidelines require that the treatment of fractures and dislocations be billed as an inclusive charge, called "fracture care". This fee includes the application of the initial cast and follow-up office visit for a global period, which may be as long as 90 days. This fee does not include the initial office visit, re-application of casts, casting supplies or x-rays. These guidelines are determined by national standards. Many plans classify fracture care in the same category as minor surgery. Therefore, these claims may be processed using surgical benefits, and may require additional payment from you for deductible and/or coinsurance.

13. There is a $30.00 returned check fee. In the event of a returned check, please contact the billing department immediately. Bad checks are referred to the Dallas County District Attorney 10 days after we have notified you in writing of the NSF payment. If a check is returned, we can no longer accept checks from you.

14. There is an 18% interest charge per month on outstanding accounts over 30 days past due. There is a 50% up charge applied to accounts referred to our collection agency.

15. Any accounts referred to an outside collection agency will have applicable fees assessed to them.

16. There is a **$35.00** charge for any forms that our office must complete, such as disability/family leave paperwork.

The fee for letters requested, that Dr. Hanssen must write, varies.

I_____, do hereby affirm that I have read and understand the above office policies. I hereby assign to Dr. Christopher J. Hanssen, M.D., all medical and surgical benefits, to which I or my dependents are entitled. I authorize Dr. Christopher J. Hanssen, M.D., to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I understand that I am responsible for all medical fees during my treatment with Dr. Christopher J. Hanssen, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

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