IS YOUR INJURY WORK RELATED? YES / NO ??

IF YOU CHOOSE NOT TO FILE ON W/COMP AND FILE YOUR OWN INSURANCE YOU UNDERSTAND YOU CAN NOT GO BACK AND FILE ON W/COMP. X_____

PLEASE PRINT LEGIBLY

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

(CELL): _____ (HOME): _____ (WORK): _____

Social Security #: _____ Marital Status: D / M / S / W

Employer: _____ Prim Dr: _____ PHONE: _____

EMERGENCY CONTACT INFORMATION:

Name of Emergency Contact: _____ Relationship: _____

Phone Number: _____

INFORMATION ON THE INSURED INDIVIDUAL

THIS IS THE INDIVIDUAL WHO CARRIES THE INSURANCE POLICY.

Patient's relationship to the insured: DEPENDENT / LOP / SELF / SPOUSE / STEP PARENT / WCOMP

Type of payment (CIRCLE ONE): CASH PAY INSURANCE LOP WORKERS COMP

Individual Insured's Name: _____ Insured's DOB: _____

Individual Insured's Address: SAME AS ABOVE OR _____

_____

Insured's Social Security #: _____ Insured's Employer: _____

Who can we thank for referring you to Dr. Hanssen: _____

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
_____	_____	_____
_____	_____	_____
_____	_____	_____

ATTY: _____

*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).
- ☐ PROCEDURES AND/OR SURGERIES.
- ☐ RADIOLOGY FILMS/CD ETC.
- ☐ PICK UP MEDICAL RECORDS.
- ☐ MEDICATIONS.
- ☐ TEST AND/OR LAB RESULTS.

➡ _____ ___/___/2014

SIGNATURE OF PATIENT OR GUARANTOR IF PATIENT IS UNDER 18 DATE

RELATIONSHIP TO PATIENT: _____

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.

3. Please have your insurance card ready. We must have a copy of your current insurance card. If you do not have a valid insurance card, we will hold you responsible for the full amount of the charges. Please inform our office 24 hours prior to your appointment if your insurance has changed.

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

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

6. ***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.***

7. 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.

8. 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 you're 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.

9. 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.

10. 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.

11. If you're 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.

12. 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, HOLIDAYS, OR BY OUR ON CALL PROVIDERS. Replacement prescriptions for prescriptions that were lost will be reissued at a charge of $15.00 per prescription.

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

14. 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.

15. 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.

16. There is an 18% interest charge per month outstanding accounts over 30 days past due. We apply a 50% up charge for accounts referred to our collection agency.

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

18. There is a $30.00 charge for any forms that our office must complete.
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, all medical and surgical benefits, to which I or my dependents are entitled. I authorize Dr. Christopher J. Hanssen, 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. 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.

➡ _____ ___/___/2014

SIGNATURE OF PATIENT OR GUARANTOR IF PATIENT IS UNDER 18 DATE

RELATIONSHIP TO PATIENT: _____

CONSENT FOR TREATMENT

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

_____

SIGNATURE OF PATIENT OR GUARANTOR IF PATIENT IS UNDER 18

RELATIONSHIP TO PATIENT: _____

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.

_____ ___/___/2014

SIGNATURE OF PATIENT OR GUARANTOR IF PATIENT IS UNDER 18 DATE

RELATIONSHIP TO PATIENT: _____

COLE CLINIC

COPAYS / CO-INSURANCE:

All co-payments are due at the time of service. We are in contract with your insurance company. Therefore, all co-pay will be collected upfront. The amount of your co-pay is listed on your insurance card. Or you may contact your insurance company to get your benefit information.

PRIVATE OR PPO INSURANCE PATIENTS:

We will bill your primary and secondary insurance providers. Please be aware that we do not coordinate with tertiary insurance providers. It is the patient's responsibility to file to the tertiary (3rd) insurance company. The patient is responsible for any unpaid balances that the insurance companies may leave to the patient's responsibility.

MEDICARE PATIENTS:

We do accept Medicare assignment. We will bill Medicare directly, as well as any secondary insurance companies. We do not coordinate with tertiary (3rd) insurance providers. The patient is responsible for filing the tertiary (3rd) insurance and will be liable for any unpaid balances.

ALL PATIENTS:

Please be aware that insurance companies offer myriad coverage's and it is your responsibility to understand your insurance plan. This may change over time, so we recommend that each patient contact their insurance company and become familiar with their insurance policy. The patient is responsible for all unpaid balances.

My signature below indicates my authorization that my insurance benefits are to be paid directly to DR. CHRISTOPHER HANSSEN MD. I am financially responsible for any charges and/or services not covered by your insurance company. I also authorize the physician and his staff to release any information required. I have received the notices of privacy and disclosure and have been provided opportunity to review them.

➡ _____ ___/___/2014

SIGNATURE OF PATIENT OR GUARANTOR IF PATIENT IS UNDER 18 DATE

RELATIONSHIP TO PATIENT: _____

Dr. Christopher Hanssen
4716 Alliance Blvd Pav#2 Ste#216
Plano, Texas 75093
469-296-3640
Specializing in Orthopaedic Surgery

Cole Clinic

ATTENTION

Our office is now filing prescriptions electronically when possible. In an effort to make this a smooth transition, please provide us with your pharmacy information.

Patient Name: _____

Date of Birth : _____ Gender: Male or Female

Address: _____

City: _____ State: _____ Zip code: _____

Email: _____

Pharmacy Name: _____

Pharmacy Number: _____

Pharmacy Address: _____

City: _____ State: Texas Zip code: _____

If address unknown cross streets: _____