Rhyneer Caylor Clinic

Specialty Orthopedic Care & Advice

NEW PATIENT WELCOME

Dear New Patient:

We look forward to meeting you and assisting you with your orthopedic care. In order to provide comprehensive, coordinated, and effective care, some preparation is required for your first visit to the clinic. Please review the contents of this “New Patient Packet” carefully. The (3) forms that need to be completed prior to your visit are included in this packet.

Information for the day of your appointment:

- Rhyneer Caylor Clinic is located at 4100 Lake Otis Parkway, Suite 308, Anchorage, AK
- Please arrive a few minutes prior to your scheduled appointment time in order to complete the registration process.
- Items to bring with you include:
  The attached three forms (completed):
  - **New Patient Demographic Form**
  - **PHI/HIPAA Signature Form (see *Notice of Privacy Practices* in office)**
  - **Rhyneer Caylor Clinic Financial Policy**
  - Picture ID
  - Insurance card(s)
  - Any consultation requests or referrals if one has been given.
  - Prior medical information that could help us find answers for you (i.e. lab results, x-rays, office or hospital visit notes, operative reports, MRI films/reports, etc.)
  - A list of medications that you are currently taking

Insurance and Billing Information:

We accept most forms of insurance and will bill your insurance company directly as a courtesy. We do suggest that you contact your insurance company prior to your appointment to verify your coverage/benefits.

Thank you for your preparation and attention to these important details. Please feel free to bring a family member or friend to your visit. It can also be helpful to share a written list of your questions or concerns with us at the beginning of your visit to assist us in addressing your needs and priorities.

Sincerely,

Rhyneer Caylor Clinic

Rhyneer Caylor Clinic – NEW PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION

Name: ______________________
Address: ______________________
City,State, Zip: ______________________
Home Phone: ______________________
Work Phone: ______________________

Date of Birth: ____________ Age: ____________
Social Security #: ____________ Sex: [ ]M [ ]F
Marital Status: [ ]Married [ ]Single [ ]Divorced
Referring Physican: ______________________
Cell/Pager Phone: ______________________

PATIENT EMPLOYMENT INFORMATION

Employer's Name: ______________________
Employer's Phone: ______________________
Occupation: ______________________

EMERGENCY CONTACTS

Name	Relationship	Phone

RESPONSIBLE PARTY (If patient is under 18 years of age)

Name: ______________________
Address: ______________________
City,State, Zip: ______________________
Date of Birth: ______________________

Employer: ______________________
Home Phone: ______________________
Work Phone: ______________________
SSN: ______________________

PRIMARY INSURANCE

Insurance Co Name: ______________________
ID #: ____________ Group #: ____________
Subscriber's Name: ______________________
Subscriber's Phone #: ______________________
Patient's Relationship: ______________________
Subscriber's Employer: ______________________
Subscriber's SSN: ______________________
Subscriber's Date of Birth: ______________________

SECONDARY INSURANCE

Insurance Co Name: ______________________
ID #: ____________ Group #: ____________
Subscriber's Name: ______________________
Subscriber's Phone #: ______________________
Patient's Relationship: ______________________
Subscriber's Employer: ______________________
Subscriber's SSN: ______________________
Subscriber's Date of Birth: ______________________

WORK RELATED INJURY

Only applicable if injury is related to work or auto accident

Insurance Carrier Name: ______________________ Address: ______________________
City, State, & Zip: ______________________ Phone: ______________________
Claim Number: ____________ Date of Injury: ____________ Employer @ time of Injury: ____________

How were you injured?______________________

_______ Right _______ Left _______ Injury _______ Discomfort _______ Sport _______ Fall _______ Other

Were you injured on the job? _______Yes _______ No Date of Injury ______________________

Employer at time of injury ______________________

Was this a motor vehicle accident? _______Yes _______No Date of accident ______________________

Auto Insurance Carrier (Yours) ______________________ Claim # ______________________

WE DO NOT BILL THIRD PARTY.

Have you had X-rays? ____________ Have you had an MRI? ____________ Do you have CD/Films with you? ____________

______________________________ ______________________

PATIENT/GUARDIAN SIGNATURE **DATE**

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FINANCIAL POLICY

Thank you for choosing **Rhyneer Caylor Clinic** for your orthopedic care. We are committed to the success of our patients. Your support is essential to the continuation of this clinic.

Please understand that a mutual financial understanding is part of our relationship. We are more than happy to bill insurance as a courtesy to our patients provided insurance information is given to us at the time of service. We require that full payments of deductible, coinsurance/co-pay, or non-covered services are paid at the time of your visit. Self pay patients are required to pay in full unless prior payment arrangements are made. Our billing line is 273-0110.

All charges are ultimately patient responsibility. We bill as a courtesy to our patients. If you are uncomfortable giving us your **social security number**, we ask that you pay for your visit in full and we will send your claim in so you are reimbursed by your insurance company. **It is never our intention to cause hardship to our patients, only to provide them with the best care possible with the least amount of stress.**

WE ACCEPT cash, check, and Visa or MasterCard credit cards.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination or usual and customary rates. Our office is willing to work with you to settle your account, please speak with our staff if you need assistance.

Returned Checks
The charge for a returned check is $30 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Workers' Compensation and Automobile Accidents
In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Please help us serve you better by keeping your scheduled appointments. If you are unable to make your appointment, please call our office to cancel or reschedule your appointment 24 hours prior.

Our office does require a $500.00 deposit prior to any surgery/procedure. Please call our office and speak to our office manager to make arrangements or for any questions at 563-2663.

Signed____ Date________________

4100 Lake Otis Parkway, Suite 308 Anchorage, AK 99508
907-563-2663 Fax 907-333-2948 Tax ID#37-1545785
www.RhyneerClinic.com

Rhyneer Caylor Clinic, PC

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HIPAA Protected Health Information (PHI) Form

Patient Name: ____

____ I understand that I am ultimately responsible for all charges incurred by me. I authorize my insurance company(s) to pay RHYNEER CAYLOR CLINIC for those charges I have not paid in full and which are filed by the Clinic on my behalf. In the event that my insurance company(s) pay RHYNEER CAYLOR CLINIC a fee that I have already paid, I understand that I will be promptly reimbursed.
Initial

____ I authorize RHYNEER CAYLOR CLINIC to release any medical information required by my insurance company or worker's compensation carrier for the processing of any medical claims filed on my behalf.
initial

____ I understand photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that RHYNEER CAYLOR CLINIC will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required as outlined in RHYNEER CAYLOR CLINIC's policy. Images that identify me will be released and/or used outside RHYNEER CAYLOR CLINIC only upon written authorization from me or my legal representative only if they are released for purposes other than treatment, payment or healthcare operations.
initial

____ I acknowledge that I have received RHYNEER CAYLOR CLINIC's ***Notice of Privacy Practices*** (please see Initial notice in office), which describes how medical information about me may be used and disclosed.

____ I have read and signed the ***Rhyneer Caylor Clinic Financial Policy***
initial

____ I acknowledge that **FMLA** forms (time off work) or **disability forms** may take 5 business days to be completed.
initial

I give permission for RHYNEER CAYLOR CLINIC to speak to the following people regarding my medical Initial and/or billing information:

____

____

(Please list name(s) and relationship on the above lines

____

PATIENT/GUARDIAN SIGNATURE DATE

Rhyneer Caylor Clinic

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Verification of Insurance Coverage/Benefits

Patient's Name: Date:

Name of Insurance Company:

Insurance Company Address:

ID#:

Group Number:

Name of Insured:

Insured's DOB:

Insured's SSN:

Address:

Employer:

My Insurance Coverage **effective date** is: ____

My **deductible** is: _________________________, I have met _________________________so far towards my deductible.

I have an **Out Of Pocket/Coinsurance Maximum** of: ___________________________________, I have met _______________________________so far towards my Out Of Pocket/Coinsurance Maximum.

My insurance pays at: ____________________% after deductible

Is **Prior-Authorization** required before your visit? ____________________________