



New Patient Registration Information



Dear WellSpan Orthopedics' Patient:

Welcome to WellSpan Orthopedics. Thank you for allowing us the opportunity to assist with your health care needs. We value all of our patients and are committed to providing you with high-quality, health care services.

This packet includes all of the new patient forms that will need to be completed in order for us to assist with your care.

1. Financial policy
2. Insurance signature on file
3. Information release
4. Patient health history
5. Patient questionnaire
6. Records release (this form only needs to be completed if you have records at another physician office that WellSpan Orthopedics would need for the appointment)

Please take a few moments prior to your appointment to review and complete the registration forms. We ask that you bring the completed forms to your appointment along with your insurance card.

Please arrive 15 minutes early for your appointment. Directions to the practice can be found on our Web site at www.wellspan.org.

The physicians and staff of WellSpan Orthopedics are looking forward to assisting you with your health care needs. If you have any questions, please call the practice at 717-339-2500 and someone will be happy to help you.

Sincerely,

WellSpan Orthopedics



Financial Policy

WellSpan Medical Group wants to provide our community with healthcare services and, at the same time, keep costs under control. To do this, we need your help. We ask you to read our payment policy listed below:

- Your bill is based on the services you received. You are responsible for paying the bill if your insurance company does not cover all the costs.
- What your health insurance covers is based on an agreement between the company, or person who employs you, and the insurance company.
- You need to contact your insurance company with any questions about what they will cover.
- We know that temporary financial problems can sometimes prevent you from making a payment on your account on time. If this happens, you need to contact us at (717) 851-6816 or 800 839-1404 at once so we can help you with this problem. Wellspan Medical Group will help to arrange a budget plan. If there is a need, we will help you to apply for Medical Assistance or our own Hardship Program.
- Any bill not paid by the date it is due will be sent to a collection agency.

IF YOU DO NOT HAVE HEALTH INSURANCE

Your Responsibility

- You must pay your entire bill at the time of service or inform us of your inability to pay.

Our Responsibility

- WellSpan Medical Group will provide the services you need, even if you cannot pay. We will not provide services if you are able to pay but choose not to pay.
- We are willing to talk to you about ways to pay, if you cannot pay the full amount.

IF YOU HAVE HEALTH INSURANCE

We *participate* with many insurance companies. This means we have signed a contract with them to provide care for the people they cover. The contracts are not all the same, and certain services may not be covered depending on your employee health benefits.

If we DO participate with Your insurance plan (including Medicare):

Your Responsibility

- You must pay any co-payment at the time you receive the service.
- You must pay any deductible amount or any amount that you know is not covered at the time of service.
- You must pay the amount not paid by your insurance within 18 days of getting your bill, except for those from whom WellSpan Medical Group can not collect by law or agreement. If you do not pay we will begin collection efforts.

Our Responsibility

- We will send a bill to your insurance company for all services done in our offices.

If we DO NOT participate with your insurance plan:

Your Responsibility

- I. You must pay for the service at the time it is given
To make it simple, our office accepts cash, checks, VISA, MasterCard, Discover, MAC (debit), and bank drafts.
We will charge you a \$25.00 fee for any returned checks.

Our Responsibility

- II. After you have paid us, we will send your bill to your insurance company. Your insurance will then pay you.

STATEMENT OF FINANCIAL RESPONSIBILITY

The patient who receives care and treatment from WellSpan Medical Group must pay any charges that are not paid by insurance or any other party.

Other providers, such as x-ray or laboratory, will bill the patient separately.

The patient must pay any amount not paid by insurance, within (18) days of the getting the bill. If WellSpan Medical Group needs to use a collection agency or attorney to collect the unpaid amount, the patient may be charged for all fees and costs to WellSpan Medical Group by the agency or attorney.

Organizations from which you may receive a bill

Wellspan Medical Group – Physician Billing Services WellSpan Orthopedics – Gettysburg (office visit)	(800)-839-1404
Gettysburg Hospital Emergency Room visit Physical Therapy Surgery X-rays, MRI Lab EKG	(800)-842-1783
Diagnostic Imaging Radiologist reading of x-rays/MRI	(800)-637-0921
Med-East Post-Op & Surgical, Inc Durable Medical Equipment (braces)	(856)829-6898

WellSpan Health

Permission to Release Diagnostic/Medical Information to Another Individual

Effective Date:* _____

Print Patient's Full Name: _____

Patient's Date of Birth: _____ MR#: _____

I give WellSpan Health entities permission to release diagnostic test results to, and discuss protected health information with, the following person(s):

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

I give WellSpan Health entities permission to leave any protected health information on an answering machine or voicemail.

Yes No

Indicate your relationship to the patient: Patient Patient Representative

Print Name (if other than patient)

Signature

Date

PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: _____ **Sex: M / F** **DOB:** _____ **Date:** _____

List All Prescriptions and over-the-counter medications, supplements and vitamins you take including the dose or strength

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Allergies: _____

Latex Allergy: Yes / No

PAST MEDICAL HISTORY

Do you have now or have you ever had any of the following?

Heart Disease	Yes	No	Hyperthyroid	Yes	No
Heart Attack	Yes	No	Kidney Stones	Yes	No
Heart Arrhythmia	Yes	No	Kidney Disease	Yes	No
Atrial Fibrillation	Yes	No	Stroke	Yes	No
Congestive Heart Failure	Yes	No	Gallbladder Disease	Yes	No
Hypertension	Yes	No	Anemia	Yes	No
Vascular Disease	Yes	No	Chronic Back Pain	Yes	No
Diabetes	Yes	No	Rheumatoid Arthritis	Yes	No
* Insulin Dependent	Yes	No	Lyme Disease	Yes	No
* Non-Insulin Dependent	Yes	No	Psoriasis	Yes	No
High Cholesterol	Yes	No	Depression	Yes	No
Lung Disease	Yes	No	Osteoporosis	Yes	No
Asthma	Yes	No	Neuropathy	Yes	No
Reflux Disease (GERD)	Yes	No	Hypothyroidism	Yes	No
Ulcers	Yes	No	Fibromyalgia	Yes	No
Cancer (location) _____	Yes	No	Colitis	Yes	No
Blood Clots (DVT or PE)	Yes	No			

Other: _____

PAST SURGICAL HISTORY

Please list any operations you have had:

WELLSPAN ORTHOPEDICS GETTYSBURG INTAKE QUESTIONNAIRE

-Please Answer All Questions-

Name: _____ DOB: _____ Date: _____

Briefly describe your problem in a word or two (ie. low back or right shoulder pain, light knee swelling)

How long have you had the problem? (ie. week, year)

How did it start? (If an injury or MVA give date)

Where did it begin? (home, work, school, on the road)

What have you done to treat it? (Seen another M.D., therapist, chiropractor, arthritis or pain medication. Please list)

Who referred you here?

Describe your symptoms or pain (Circle any that apply)

Quality: sharp, dull, aching, stabbing, throbbing, other: _____

Severity: minor, moderate, severe

Duration: intermittent, constant

Timing: working, sleeping, driving, sitting, standing, exercising, other

Context: getting better, worse, staying the same

Associations: swelling, bruising, tingling, numbness spasms, giving way, locking, other: _____

What makes it better?

What makes it worse?



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize:

Address: _____

Receive from: _____

Disclose to: _____
Address: _____

The following information regarding my

Please check all that apply

Inpatient care on _____
Specify dates of admission/discharge

Outpatient care on _____
Specify dates of clinic visits or outpatient procedure

Emergency care on _____
Specify dates of Emergency Department visits

Please Check (4)

- | | | |
|---|--|---|
| <input type="checkbox"/> Complete Medical Records | <input type="checkbox"/> History and Physical Examinations | <input type="checkbox"/> X-Ray, Imaging Reports |
| <input type="checkbox"/> Hospital Discharge Summary | <input type="checkbox"/> Records from Other Providers (please specify) _____ | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Consultations | | <input type="checkbox"/> Cardiac/EKG Reports |
| <input type="checkbox"/> Other (please specify) _____ | | |

The purpose for disclosing the above information is indicated by a check mark (4) below:

- Continuing Care Relocation Insurance Legal Other ((please specify) _____

I understand that I have no obligation to disclose information from my record and that I may revoke this authorization by submitting a request in writing along with a copy of this form to the Practice Manager of this office. I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions.

The signing of this authorization is not a condition for providing treatment.

I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the information may be re-disclosed and no longer be protected by federal privacy regulations. However, certain protected records such as drug and/or alcohol use, abuse, treatment, or referrals for treatment; HIV information; and mental health services may not be re-disclosed per Pennsylvania state laws and regulations and/or Federal confidentiality rules.

My signature acknowledges that I have read and understand the contents of this authorization and voluntarily consent to the release of information as stated including release of any records identified below unless I check here to not disclose such records. Checking or not checking the box is no indication that such information exists. Records **NOT** to disclose:
 HIV information; Mental health services; Drug and/or alcohol use, abuse, treatment, or referrals for treatment.

My signature also acknowledges receiving a copy of the document.

THIS AUTHORIZATION SHALL EXPIRE 12 MONTHS FROM THE DATE EXECUTED UNLESS OTHERWISE SPECIFIED BY THE PATIENT:

Print Patient's full name

Signature of Patient/Responsible Party

Date

Patient's Date of Birth

Relationship to Patient

Patient's Social Security Number

Witness Signature

Date

NOTE: THIS AUTHORIZATION WILL NOT BE ACCEPTED UNLESS IT IS COMPLETED IN ITS ENTIRETY.
A COPY OF THIS FORM WILL BE ACCEPTED IN LIEU OF AN ORIGINAL.
A COPY OF THIS AUTHORIZATION IS TO BE GIVEN TO THE PATIENT OR PATIENT REPRESENTATIVE.

Patient Name: _____ DOB: _____

THIS PORTION TO BE COMPLETED WHEN A PATIENT IS UNABLE TO GIVE WRITTEN CONSENT:

We, the undersigned, do verify that the above authorization has been read to the patient and that he/she understands the nature of the release and freely gives his/her verbal consent for release of the information.

***Verbal Consent requires
signatures of two witnesses***

Signature of witness

Date

Signature of witness

Date

