The Centers for Advanced Orthopaedics
NOVA Orthopaedics and Sports Medicine Center

8206 Leesburg Pike, Ste 409
Vienna, VA 22182
Tel: (703) 288-0094
Fax: (703) 288-0673
Email: ortho@novaosmc.com

# PATIENT REGISTRATION



**Today's Date: _____**

## PERSONAL INFORMATION

| | | |
|---|---|---|
| Last Name: | | Salutation: |
| First Name: | | M.I.: |
| DOB: | SSN: | Sex: |
| Home Address: | | |
| City: | State: | Zip Code: |

Preferred Contact: Leave a voice message ❑ YES ❑ NO
❑ Home ❑ Work ❑ Cell ( )

Alternate Contact:
❑ Home ❑ Work ❑ Cell ( )

*E-mail Address: _____

Language Preference: ❑ English ❑ Español ❑ Tiếng Việt

Race: ❑ African American ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Other

Marital Status:
❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Employment Status:
❑ F/T ❑ P/T ❑ Self ❑ Retired ❑ Student ❑ Other

Employer:

*I allow CAO-NOVAOSMC to email/voice message me appointment reminders, account updates and policy changes. My personal information is not shared with 3rd parties.

## EMERGENCY CONTACT*

| | | |
|---|---|---|
| Last Name: | | Salutation: |
| First Name: | | M.I.: |
| Relationship to Patient: | | Sex: |
| Address: (❑ Same as patient, or specify) | | |
| City: | State: | Zip Code: |

Primary Contact:
❑ Home ❑ Work ❑ Cell ( )

Alternate Contact:
❑ Home ❑ Work ❑ Cell ( )

*I allow CAO-NOVAOSMC to discuss my clinical care with my emergency contact.

## PRIMARY INSURANCE

Policyholder Name: (❑ Self, or specify)

| | |
|---|---|
| Relationship to Patient: | Policyholder DOB: |

Insurance:

Member Number:

Group Number:

## SECONDARY INSURANCE

Policyholder Name: (❑ Self, or specify)

| | |
|---|---|
| Relationship to Patient: | Policyholder DOB: |

Insurance:

Member Number:

Group Number:

## SELF-PAY

❑ Yes (please ask about self-pay fees)

## AUTO ACCIDENT/WORKER'S COMPENSATION

❑ "Addendum A" Attached ❑ "Addendum B" Attached

## PHARMACY

| | |
|---|---|
| Company: | Phone: ( ) |
| Location: | |

## REFERRAL SOURCE

Primary Care Physician (PCP):

*Whom should we thank for your referral to CAO-NOVAOSMC?*

_____

❑ Physician/Office ❑ Hospital ❑ Urgent Care ❑ Radio/TV
❑ Current Patient ❑ Internet ❑ Newspaper ❑ Magazine

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# PATIENT REGISTRATION



_____ (Initials)

**Authorization for Claims, Payment and Review (Pink)**

By initialing, I acknowledge that I have read, understand and agree to the "Authorization for Claims, Payment and Review" regarding my financial responsibility for any balances including but not limited to rendered treatment and associated collection fees, legal fees, administrative fees, postage, returned checks fees and any other balances due to applicable fees as outlined in the "Practice Terms and Policies."

_____ (Initials)

**Practice Terms and Policies (Yellow)**

By initialing, I acknowledge that I have read, understand and agree to the "Practice Terms and Policies" regarding office services and fees. I am aware that there is a fee for no-shows and cancellations made less than 24 hours for office appointments or less than 5 business days for surgeries. CAO-NOVAOSMC reserves the right to revise its Terms and Policies at any time; the latest fees are available at the time of service.

_____ (Initials)

**HIPAA Privacy Standard (Green)**

By initialing, I acknowledge that I have read, understand and agree to the "HIPAA Privacy Standard" regarding the use and disclosure of Protected Health Information (PHI) per the Health Insurance Portability and Accountability Act of 1996 (HIPAA). CAO-NOVAOSMC reserves the right to revise its Practice Privacy Notice at any time; the latest revision is posted in the office and may be obtained by written request.

_____ (Initials)

**Consent Agreement**

With this consent, CAO-NOVAOSMC may seek payment from insurance carriers and/or payor entities for benefits of services rendered to me. I request payment from my insurance carrier and/or payor entity to be made directly to CAO-NOVAOSMC at 8206 Leesburg Pike, Suite 409, Vienna, VA 22182.

CAO-NOVAOSMC may call, mail or e-mail my home or my approved points of contact to leave a message on voice mail or in person in reference to any items that assist CAO-NOVAOSMC in carrying out TPO, such as appointment reminders, insurance items, clinical care, among other pertinent information so long as written items are marked "Personal and Confidential."

I have the right to request that CAO-NOVAOSMC restrict how it uses or discloses my PHI to carry out TPO. CAO-NOVAOSMC is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, CAO-NOVAOSMC may decline to provide treatment to me. A photocopy of this consent may be honored.

I certify that my personal, insurance and acknowledgement information herein this Patient Registration Form including applicable "Addendum A," "Addendum B" and any attachments are true, accurate and complete to the best of my knowledge.

_____ Patient Signature, or Legal Representative

_____ Date

_____ Patient Printed Name, or Legal Representative

_____ Relationship to Patient if Legal Rep.