pb&j | princeton bone and joint

5 Plainsboro Road, S Road, Suite 100
Plainsboro, NJ 08536

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info@pbnj.com
www.pbnj.com

Dear New Patient,

Welcome to Princeton Bone & Joint. We are honored that you have chosen us as your orthopaedic health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

This information packet includes:

- Princeton Bone & Joint Brochure
- Patient Demographics Form
- Medical History Form
- Privacy Policy
- Cancellation and No Show Policy
- Assignment of Benefits Form
- Financial Policy Agreement
- Orthopaedic OMR Sheets (bubble sheets)

Kindly complete these forms and give them to the receptionist along with your insurance card and photo ID, as well as referral and copay (if applicable).

We encourage you to make a list of any questions you may have. You will find we are dedicated to excellence in patient care, and we look forward to participating in your orthopaedic health care needs.

Sincerely,

The Staff of Princeton Bone & Joint

Princeton Bone & Joint, LLC
Financial Policy

Princeton Bone & Joint believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible healthcare for you, and we want you to completely understand our financial policy.

1. **Insurance.** We are a participating provider with most insurance plans. Please call your insurance company to verify that we participate with your insurance. Our biller will file all insurance claims. Please remember that insurance is a contract between the patient and the insurance company, and ultimately the patient is responsible for payment in full.

   Due to the many different types of insurance policies, our staff cannot guarantee your eligibility and coverage. Please be sure to check with your insurer's member benefits department about services and physician before your appointment. You, the patient, are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim is rejected due to the lack of a referral. Alternatively, you may be asked to reschedule your appointment.

   Not all insurance plans cover all services. In the event that your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

2. **Payment** is expected at the time of your visit for any unmet deductible, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, payment is expected in full at the time of your visit. We will accept cash, check, or credit card.

3. **Worker's Compensation** patients are asked to provide case number and case manager information prior to being seen and to have this information available. Otherwise, we may need to reschedule your appointment.

4. **Late Charges** will be applied to all patient balances that are 90 days old or greater.

5. **Billing office**. Our billing office will assist you with any questions in regard to any of your billing statements. The Accounts Receivable Staff at Management Resource Group is available at 877-878-9294 x 376.

5. **Collection fees.** In the event a patient's account is placed in collection status, any additional fees incurred due to this will be added to the outstanding balance. This includes but is not limited to collection agency fees, court costs, interest, and fines. These additional fees are the patient's responsibility to pay in full.

6. **Charity Care.** Princeton Bone & Joint provides charity care through the hospital clinic several times per year in rotation with other orthopaedic surgeons. We do not support this in the main office.

7. **Surgery.** We request a deposit of 50% of your estimated out-of-pocket expenses, including deductible and copay, in order to schedule surgery. Our surgery scheduler can provide an estimate based on your specific account through our clearing house and set up payments through a credit card, as needed.

I have read and understand the practice's financial policy, and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice, as needed.

_____ _____
Signature of Patient (or Guarantor, if applicable) Date

_____ _____
Print Name

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Cancellation / No Show Policy:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails
to cancel, and we are unable to schedule you for a visit due to a seemingly "full" appointment book. This is particularly important in physical therapy. Not keeping therapy appointments is detrimental to your recovery, and no show appointments mean that this time cannot be filled. We will provide you with reminder texts, emails and phone calls to assist you in complying with this policy.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

Scheduled Appointments Policy:

We understand that delays can happen, however, we must try to keep the other patients and doctors on time.

If a patient is 20 minutes past their scheduled time we may have to reschedule the appointment.

Print Patient Name	Signature Patient/Guardian	Date

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Medical History

NAME: _____

DATE OF BIRTH: _____ AGE: _____

CHIEF COMPLAINT (reason for visit, body part injured): **LEFT** or **RIGHT** extremity involved.

_____
_____
_____
_____

When did symptoms begin (date of injury, rough estimate of onset)? _____
_____

Please indicate if this is due to: Motor Vehicle _____ Worker's Comp. _____

SPECIFIC SYMPTOM COMPONENTS (include location, severity, when occurs, quality, duration, context, associated symptoms)

_____
_____
_____

PAST MEDICAL HISTORY: Please list all hospitalizations (including surgeries) with problem, approximate date, location of hospital, and treating physician:

Problem	Date	Hospital	Physician

List all medications with dosage and frequency; be sure to include MAO inhibitors, anticoagulants:

Medications (attach list if extensive)	Dosage	Frequency

Drug Allergies or Adverse Reactions (include nickel, latex,penicillin, aspirin, anti-inflamatory drugs, local anesthetic):

[ ] No Known Allergies

_____

_____

PHARMACY Name:_____ Street/Town:_____

_____

SOCIAL HISTORY:

Marital Status: single / married / separated / divorced

Dominant hand: Right / Left

Activity Level	Frequency of Exercise	Type of Exercise
Sedentary (1 MET)	None	Walking
Moderate (3-6 METs)	1x per week	Jogging
Vigorous (>6 METs)	2x per week	Treadmill
	3 x per week	Cycling
	Daily	Sports
		Weight Training
		Yoga/ Pilates

Hobbies/Activities: _____

Type of Diet: _____

Occupation: _____ Retired / Disabled / Unemployed

REVIEW OF SYSTEMS:

General Health: Excellent / Good / Fair / Poor

Height: _____ Weight: _____ constant / recent loss / recent gain

Signature of person completing form

Signature: _____Date:_____

Relationship to Patient: _____

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Notice of Privacy Practices
Patient Acknowledgement

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of Health and Human Services if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of The Notice of Privacy Practices from this practice upon request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

Princeton Bone & Joint, LLC

New Patient Demographics Form:

Patient Information Date Completed (mm/dd/yyyy):_____

Last Name:_____ First Name:_____

Middle Initial:_____

Prefix(Dr./Mr./Ms.): _____ Suffix(Jr.,III): _____

Street Address, line 1:_____

Street Address, line 2:_____

Home City:_____ Home State:_____Home Zip:_____

Home Phone:_____ Mobile Phone:_____

Sex(M/F):_____ Date of Birth(mm/dd/yyyy):_____

Marital Status(M/S/D/W):_____ Social Security Number:_____

Preferred Email Address:_____

Patient Employment

Status(employed/unemployed/disabled):_____

Employer Name:_____

Employer Street Address:_____

Employer City:_____ State:_____ Zip:_____

Occupation:_____

Guarantor Information

Last Name:_____First Name:_____Middle Initial: _____

Prefix(Dr./Mr./Ms.): _____ Suffix(Jr.,III): _____

Relationship to Patient: _____

Street Address, line 1:_____

Street Address, line 2:_____

Home City:_____ Home State:_____Home Zip:_____

Home Phone:_____Mobile Phone:_____

Fax:_____

Sex(M/F):_____ Date of Birth(mm/dd/yyyy):_____

Marital Status(M/S/D/W):_____Social Security Number:_____

Preferred Email Address:_____

Guarantor Employment

Status(employed/unemployed/disabled):_____

Employer Name:_____

Employer Street Address:_____

Employer City:_____State:_____Zip:_____

Occupation:_____

Physician Information

Referring Physician Name: _____

Referring Physician Phone:_____Fax:_____

Primary Physician Name:_____

Primary Physician Phone:_____Fax:_____

Ethnicity Declined / Hispanic or Latino / Not Hispanic or Latino

Race Indian or Alaska Native / Asian Indian / Black / Asian or Pacific Islander / White / Declined

Language English / Spanish / Other:_____

How did you hear about us?

- Primary Care Physician
- Another Patient
- Insurance Directory
- Friend or Family member
- Newspaper, please specify_____
- Yellow Pages
- Radio, please specify station_____
- Website, please specify _____
- Emergency Department
- Hospital

Signature of person completing form

Signature: _____Date:_____

Relationship to Patient: _____

Princeton Bone & Joint, LLC

PATIENT SATISFACTION SURVEY

It is our goal to give you the best possible medical care. To do that, it is important that we know your thoughts about the care you are receiving. We need to know the areas in which we are doing well and the areas we need to improve. Your comments are strictly confidential, and results are used to accomplish quality improvement. Feel free to make any additional comments below:

_____ _____

_____

1. Is this your first visit to our Practice? __ Yes ___ No

   Or a return visit? ___ Yes ___ No

2. Which provider are you seeing today? Please circle one.

   [List the physicians and non-physician providers in your practice here.]

3. Why did you decide to seek medical treatment at this Practice? Please check all that apply.

   Sent by the emergency room ___ Yes ___ No

   Referred by a friend __ Yes ___ No

   Selected the physician from my insurance list __ Yes ___ No

   Referred by Workers' Compensation ___ Yes ___ No

   Referred by another patient ___ Yes ___ No

   Referred by another provider ___ Yes ___ No

   Near my office or home ___ Yes ___ No

   Other: _____

4. How many days in advance did you schedule your appointment? _____ days
5. Did you want to be seen sooner? ___ Yes ___ No
6. Was this appointment rescheduled by this Practice? ___ Yes ___ No
7. When you called:

   a. The phone was answered promptly ___ Yes ___ No

   b. I was put on hold temporarily ___ Yes ___ No

8. The person who answered your call was (Please circle the best number, with "1" indicating discourteous and "5" indicating very courteous.):

   1 2 3 4 5

9. How were you treated when you arrived for your appointment? (Please circle the best number, with "1" indicating unpleasant to "5" indicating very pleasant.)

   1 2 3 4 5

10. After you arrived, how long did you wait to see the provider? _____ minutes
11. The nurse or medical assistant seemed (Please circle the best number, with “1” indicating impersonal to “5” indicating very personal.):

    1 2 3 4 5
12. How did the ancillary staff (X-ray or lab technicians) treat you? (Please circle the best number, with “1” indicating impersonal to “5” indicating very personal.)

    1 2 3 4 5
13. Were you satisfied with the time the provider spent with you? (Please circle the best number, with “1” indicating very dissatisfied to “5” indicating very satisfied.)

    1 2 3 4 5
14. Regarding the reason you were seen, did the provider show indifference or interest in your problem? (Please circle the best number, with “1” indicating indifference to “5” indicating very interested.)

    1 2 3 4 5
15. The provider’s explanation of your condition and treatment was (Please circle the best number, with “1” indicating inadequate to “5” indicating excellent.):

    1 2 3 4 5
16. Were you satisfied with the overall medical treatment you received in this Practice? (Please circle the best number, with “1” indicating very dissatisfied to “5” indicating very satisfied.)

    1 2 3 4 5
17. The business office staff was (Please circle the best number, with “1” indicating not helpful or courteous to “5” indicating very helpful and courteous.):

    1 2 3 4 5

What do you think we do well at this Practice?

What do we need to change to improve our service to patients?

If you would like someone to personally contact you about any concerns or questions you have, please complete the following:

Name: _____

Address: _____

Daytime phone: _____

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HIPPA Permission to Share Medical Information Form

I, _____ acknowledge that I have received the written Notice of Privacy Practices and Record Discolsure.

[ ] The Patient's condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient's condition improves.

I wish to be contacted in the following manner: (Check all that apply)

Cell phone (____) _____ - _____
- [ ] Leave message with detailed information
- [ ] Leave message with call back number only

Home Telephone (____) _____ - _____
- [ ] Leave message with detailed information
- [ ] Leave message with call back number only

Work Telephone (____) _____ - _____
- [ ] Leave message with detailed information
- [ ] Leave message with call back number only

Written Communication
- [ ] Mail to Home address
- [ ] Mail to Work Address
- [ ] Fax to the following number: _____

I consent to have my personal health information disclosed to my:

- [ ] Family Member _____
- [ ] Friend _____
- [ ] Other _____

Patient Signature: _____

Date: _____