Gavin
Orthopaedics, LLC

MOSS CREEK ORTHOPAEDIC URGENT CARE
Scrapes • Sprains • Shots • Stitches

WELCOME TO OUR OFFICE!

☐ **Patient is a Minor**

Date_____

Last Name _____ First_____ Middle_____

Address _____Plantation_____

City_____ State_____ Zip_____ Home Phone_____

SSN _____ Date of Birth_____ Age_____ M/F_____

E-mail Address _____ Cell Phone_____

Emergency Contact Information

Name _____ Relationship_____

Address _____ Employer_____

Home Phone _____Cell Phone_____ Work Phone_____

How did you learn about our practice? _____

Has Dr. Gavin treated any of your family members before? _____

If so, who? _____ Referring Physician_____

INSURANCE POLICY INFORMATION

PLEASE HAVE YOUR ID CARDS READY

Primary Insurance _____

Policy Number _____

Secondary Insurance _____

Policy Number _____

Responsible Party Information (Insurance Policy Holder)

Name _____ Relationship_____

Address _____ Employer_____

Home Phone _____Cell Phone_____ Work Phone_____

SSN _____ Date of Birth _____

Is this visit related to an accident?

Motor Vehicle Accident? Y / N **Workers Compensation? Y / N** **Other? Y / N**

See front desk for additional paperwork regarding accident

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures:
Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of Gavin Orthopaedics. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable disease to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision to revoke your authorization.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices.
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revise notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information by submitted in writing. You may obtain a form to request access to your records by contacting our receptionists or our office manager. Your request will be reviewed and will generally be approved unless there are legal or
medical reasons to deny the request. These requests will come at a fee to you for copying and researching.

www.gavinortho.com

For your convenience, you may to our website: www.gavinortho.com and access office forms along with descriptions of the following :

- Disorders Treated
- Pre/Post Surgery Instructions
- Helpful Links
- What to Expect During Recovery
- Patient Testimonials
- Commitment to Quality Stats

PATIENT FINANCIAL POLICY AND PROCEDURE

Introduction:

Dr. Gavin's' practice is a professional business providing Orthopaedic medicine including health related diagnostic and
therapeutic services. These services are provided to its patients and clients with the expectation of making the profit needed to financially support its employees, to pay its necessary expenses, and to develop future new services.

Appointments:

Please contact our office to schedule time to see your Doctor or Physicians Assistant. Walk INS are accepted in our Urgent Care with our Physicians Assistant. Due to unforeseen circumstances you may be seen later than your appointment time. Please
understand that our staff is working very hard to give the best care and would appreciate your patience.

Confirmation policy:

Due to the nature of patient's problems and the volume of patients in Dr. Gavin's practice, the office staff confirms all upcoming appointments. A member of the office staff will call to confirm your appointment. In addition to the call, if you elect an automated system may text or email you. If you cannot be reached by the day prior to your appointment to confirm, your appointment will be canceled and will have to be rescheduled. Please inform office staff of any changes to your contact numbers to ensure you can be reached.

Cancellation policy:

If you need to cancel an appointment; a **24- hour notice policy applies.**

Charges for Professional Services:

All services will be charged to the patient according to a fee schedule determined by the office Contractual discounts to third party payers, agreed to by the office, will be honored in good faith. No fee or charge can be reduced or waived without the permission of only the administrator or billing manager. Upon request, these fees can be issued to the client.

Payment:

Payment for services is considered the patient's responsibility. All co-payments, co-insurance, balances and deductibles will be collected **at the time of service**.

Non-urgent professional service may be delayed or terminated within the guidelines of good medical practice for bad-faith patient noncompliance with this financial policy.

Insurance:

Health insurance is primarily a contract between the patient and the insurance company. However, Dr. Gavin's office also has contractual obligations with certain private and government entities. The patient is primarily responsible for holding the insurance company accountable for claims reimbursement. Dr. Gavin's office will make available substantial resources to facilitate insurance payment and will dedicate its resources towards its own contractual obligations with these entities.

Dr. Gavin's office will use all reasonable means to collect owed funds. Defaults in payment of agreed amounts will be automatically referred to a collection agency for payment. Please make an effort in keeping track of your records and at the discretion of the Office Manager a payment plan may be available

Responsibilities of the Patient:

The patient is expected to have knowledge of the benefits provided through their insurance carrier or third party payer. A telephone number on the back of the insurance card can usually be used to obtain this information. You may contact them at any time to see if a service will be covered or not.

At each office visit or patient encounter, the patient will provide a current mailing address and telephone number as well as current third-party information necessary for billing purposes. This information must be given to the receptionist upon signing in, or to our medical assistant as the patient is being checked out. The doctor will need to know the identity of the insurance company to make proper referrals under the managed care contract, thus, proper identification is mandatory.

The patient is to immediately make total payment when the debt is due.

The patient is to inform the office if payment arrangements need to be made, due to extenuating circumstances.

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Self- Pay Patients: IF YOU DO NOT HAVE INSURANCE YOUR PAYMENT IS DUE AT TIME OF SERVICE.

Responsibilities of the office:

The office will make a good effort to obtain necessary per-certifications for requested procedures required by contracted third parties to facilitate approval for payment. Failure to obtain per-certifications or approval from the insurance company does not necessarily mean that the requested procedure is not medically necessary; in this circumstance, the patient may be financially responsible for services ordered or rendered.

Upon receiving accurate insurance/third party information the clinic will file an appropriate American Medical Association-approved claim to the appropriate entity. The office will make a good-faith effort with help from the patient to follow up these claims to facilitate payment.

The office will fairly enforce this policy and procedure upon all patients.

I state that I have read this financial policy and procedure and have been given an opportunity to ask questions. I state that I have read and received the Notice of Privacy Practices regarding my healthcare and HIPAA. I accept this policy and procedure and will comply with it as part of my professional relationship with Dr. Gavin's offices.

Patient or Responsible Party

Printed Name: _____

Signature : _____

Date: _____

If patient is a Minor - Relationship to Patient: _____

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15 Moss Creek Village ◆ Hilton Head Island, SC 29926
Office: 843-681-5077 ◆ Fax: 843-681-5012

HIPAA PERMISSIONS

Please keep in mind, we confirm all appointments 2 -3 days in advance, if we cannot contact you or you do not call back to confirm your appointment, it will be cancelled.

What method can we use to contact you about your appointments?

☐ Phone: Preferred Number_____ Text ☐ Call ☐

☐ Email _____

May we leave messages on your voicemail with your specific appointment information?

☐ Yes ☐ No

May we release your complete medical records to your referring physician and/or your primary care physician?

☐ Yes ☐ No

I, the patient hereby authorizes J. Robert Gavin, Jr., M.D. & Michelle Hubbard PA-C to release my medical information (appointments, lab/x-ray results, diagnoses. Treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name	Date of Birth	Relationship	Phone#

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor	Phone #	Clinic

Patient Name (Printed): _____

Patient /Guardian Signature: _____ Date: _____