Please Print
❑ Germantown

Ognibene Clinics

Date: _____
❑ Whitehaven

Last Name _____ First _____ M.I. _____ Address _____

City, State, Zip _____ Phone # (_____)-_____ Social Security # _____

Emergency Name & Number _____ Patient's Date of Birth _____

Age ____ Gender M___F___ Marital Status: M___S___D___W____Race_____Cell# (___)-_____

Employer_____Address_____Phone# _____

Primary Care Dr_____Date of Last Visit _____

Referring Dr._____Date of Last Visit _____

Pharmacy Name_____Phone # _____

Insurance

Please ONLY fill out if you are not the policy holder

Name_____Address_____Phone# _____

City, State, Zip_____ID#_____Group# _____

Policy Holder's Name (if other than patient)_____Relation to patient _____

Policy Holder's Date of Birth_____Is pre-certification and/or referral authorization required? _____

Policy Holder's SS# _____

Please Circle Y (Yes) or N (No) to the following:

1) Do you smoke? Y or N
2) Are you under a physician's care? Y or N
3) Are you a diabetic? Y or N
4) Are you subject to prolong bleeding? Y or N
5) Have you ever had phlebitis? Y or N
6) Are you allergic to any medicine? Y or N
   a. If so, please list _____
7) Have you ever had any serious illness or surgeries? Y or N
8) Have you ever been treated for: Heart Trouble, Epilepsy, Kidney, Liver or Asthma? Y or N

Please give your insurance card(s) and a picture I.D. to the receptionist for a copy to be made.

A. Notifier: _____

B. Patient Name: _____

C. Identification Number: _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If your insurance doesn't pay for the item listed in Box D below, you may have to pay. Your insurance does not pay for everything, even some care that you or your health care provider has good reason to think you need. We expect your insurance may not pay for the items listed in Box **D** below.

D. Procedure in Question:	E. Reason My Insurance May Not Pay:	F. Estimated Cost
x-rays, camwalkers, splints, injections, routine footcare, orthotics, Richie Brace, and surgeries	Non-covered services, deductibles, co-insurance, out of pocket applies, no secondary insurance, or not under patient's insurance plan	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choosé an option below about whether to receive the item listed in Box **D** above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but your insurance cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the item listed in Box **D** above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me on a Explanation of Benefits (EOB). I understand that if my insurance doesn't pay, I am responsible for payment, but I can appeal to my insurance by following the directions on the EOB. If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the item listed in Box **D** above, but do not bill my insurance. I may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance is not billed.**

H. Additional Information:

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Ognibene Clinic Germantown
2120 Exeter Road, Suite 220
Germantown, TN 38138

Ognibene Clinic Whitehaven
1695 Bender Road
Memphis, TN 38116

CONSENT FOR TREATMENT AND CARE

I, the undersigned, do hereby agree and give my consent for Dr. Ognibene and/or Dr. Song to furnish medical care and treatment to myself or_____which is considered necessary and appropriate in diagnosing or treating my/their physical condition.

STATEMENT OF FINANCIAL RESPONSIBILITY

All services rendered are the responsibility of the patient. As a courtesy to our patients, we will file with your insurance carrier. The patient is responsible for all fees, regardless of insurance coverage or the usual and customary fees provided by your insurance company. Payment is expected at time of treatment unless prior arrangements have been made with our office. I understand that I will be responsible for any costs incurred as a result of my account being turned over to a collection agency or attorney. I understand that I will be responsible for a service charge for any returned checks.

INSURANCE AUTHORIZATION AND BENEFITS ASSIGNMENT

I hereby authorize Dr. Ognibene and/or Dr. Song to release all information necessary, including medical records, requested by insurance companies with whom I have coverage and any public agency or its agents to secure payment for myself or my dependents. I hereby authorize payment of benefits to be made directly to Ognibene Clinics for services provided to me or my dependents.

MEDICARE ONE - TIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Ognibene and/or Dr. Song for any services furnished me by that provider. I authorize any holder of medical information about me to determine these benefits or the benefits payable for related services.

MEDIGAP AUTHORIZATION

I request that payment of authorized Medigap benefits be made on my behalf to Dr. Ognibene and/or Dr. Song for any services furnished me by that provider, I authorize any holder of medical information about me to release any information needed to determine those benefits or the benefits payable for related services to my Medigap carrier.

CLAIM FILING CONSENT

I also agree to give Medical Insurance Filing Services, Inc. authorization necessary to file insurance for medical claims on behalf of Dr. Ognibene and/or Dr. Song. I authorize refund of overpaid insurance benefits where my coverage's are subject to coordination of benefits.

Print Name _____

Patient's Signature_____Date _____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing The Ognibene Clinic as your health care provider.
We require every patient to read and sign the following agreement before provision of care. We are happy to answer questions about this policy. If you refuse to sign this agreement, services will not be provided.

If you do not have health insurance, if The Ognibene Clinic is not contracted with your insurance plan, or if you had treatment (I.E. bone surgery at Baptist East Hospital by Dr. Tex Song) we will continue to treat you under the 90 day global period, but you will be required to pay all charges at a self-pay rate, in full, at the time of service. Should you have health insurance, it is your responsibility to provide us with complete, accurate, and up-to-date information in order for us to successfully bill your insurance company. It is your responsibility to understand your benefits. Ultimately, by signing this you acknowledge you understand and agree that it is your responsibility to pay applicable deductible, co-payments, co-insurance, and / or outstanding balances at the time of service.

Your health plan may state it considers a proposed treatment not medically necessary, investigational or not proven medically effective, even though The Ognibene Clinic believe this is the best treatment for you. Should your health plan deny payment for such services provided to you by The Ognibene Clinics, you will be responsible for all charges. If, for any reason, your health insurance does not pay for services rendered you understand that you are responsible for all charges and, by signing below, agree to pay upon receipt of a statement issued by The Ognibene Clinic. **If The Ognibene Clinic does not receive your payment within after 60 days you will be turned over to an outside collection agency to attempt to collect a debt if you do not contact us regarding a payment plan.**

I understand that this the policy of The Ognibene Clinics, which shall not change based on date of service, type of service, health plan or change of health plan coverage. I have read the policy and fully understand my responsibilities and obligations.

In the event that your account is placed with a collection agency, a collection fee of up to 33.3% may be added to your account and shall become a part of the total amount due. In the event your account is placed with an attorney, you will be responsible for the reasonable attorney fees and court costs.

You agree, that in order for us to service your account or to collect any amounts you may owe, we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages and/or emails, using any email address you provide to use. Methods of contact may include pre-recorded/ artificial voice messages and/or use of an automatic dialing device, if applicable.

Patient Name (Print) _____

Responsible Party Name (Print) _____

Responsible Party Signature _____

Date _____

Institute for Safe Medication Practices
www.ismp.org

Name: _____

Continuation of List of Current Medications

Page _____ of _____

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).

Medication (Brand and Generic Name)	Dose	How and How Often You Take the Medication	Reason for taking	Date Started	Prescriber

Date Updated: _____