UNIVERSITY ORTHOPEDICS

PATIENT NO._____ DOCTOR 2 4 5 8 14 18 20 24

Welcome To Our Office

THIS SHEET PROVIDES US WITH INFORMATION THAT WILL AID OUR OFFICE IN ACCURATELY FILING YOUR INSURANCE FORMS. BE ASSURED THAT THIS INFORMATION WILL REMAIN STRICTLY CONFIDENTIAL. PLEASE TAKE A MOMENT TO FILL OUT BOTH PAGES OF THIS FORM. IF THIS IS AN UPDATE **WELCOME BACK.** (PLEASE PRINT)

DATE_____

Patient Information

Name: (LAST)_____ (FIRST)_____ (MI)_____

Address: _____ (Street) _____ (City) ____ (State) _____ (Zip)

Martial Status: S M D **Date of Birth:** ____/____/____ **Sex:** M F

Phone: ( )_____ (Home) ( )_____ (Work) ( )_____ (Cell)

Social Security #: ____-____-____ **Email:**_____

Patient Employer Information

Employer:_____

Address: _____ (Street) _____ (City) ____ (State) _____ (Zip)

Emergency Contact Information

Name: (LAST)_____ (FIRST)_____ (MI)_____

PHONE: ( ) _____ **Relationship:**_____

Responsibility Party

(WHOM EVER IS SIGNING FOR FINANCIAL RESPONSIBILITY AND/ OR IF PATIENT IS UNDER 18 YEARS OLD)

Name: (LAST)_____ (FIRST)_____ (MI)_____

Relationship To Patient: _____

Address: _____ (Street) _____ (City) ____ (State) _____ (Zip)

Date of Birth: ____/____/____ **Social Security #:** ____-____-____

Phone: ( )_____ (Home) ( )_____ (Work) ( )_____ (Cell)

WHAT PHYSICIAN REFERRED YOU TO US?_____

Insurance Information

Is the reason for your visit related to Workman's Comp. **Y N**

Does your Insurance Carrier require a referral? **Y N** If YES , we need a copy of your referral for our records or you must sign a waiver stating you are responsible for charges today

(1) Primary Insurance _____

ID#:_____ **Group#**_____

NAME INSURANCE IS UNDER OR INSURED PARENTS NAME

Name: (LAST) _____ (FIRST)_____ (MI)_____

Address: _____ (Street) _____ (City) ____ (State) _____ (Zip)

Home Phone:( ) _____ **Social Security #:** _____-_____-_____

Employer:_____ **Work Phone**( )_____

Date of Birth _____/_____/_____

INSURED'S RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER (SPECIFY)

Please continue to next page.....

(2) Secondary Insurance _____

ID#:_____ **Group#**_____

NAME INSURANCE IS UNDER OR INSURED PARENTS NAME

Name: (LAST)_____ (FIRST)_____ (MI)_____

(FIRST)_____

Address: _____ _____ ____ _____

Street City State Zip

Home Phone:(**)** _____ **Social Security #:** _____-_____-_____

Employer:_____ **Work Phone(** **)**_____

Date of Birth _____/_____/_____

INSURED'S RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER (SPECIFY)

Contracting arrangements with your insurance carriers require us to collect the Co-Pay portion of your office visit on the date services were rendered.

PLEASE NOTE: A SERVICE FEE OF $25.00 WILL BE CHARGED FOR ANY RETURNED CHECK.

Authorization To Release Information and Payment Responsibility

I HEREBY AUTHORIZE THIS PRACTICE TO MAKE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION (PHI) NECESSARY FOR THE TREATMENT, PAYMENT, AND INSURANCE NOTIFICATION (TPI). I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY PROVIDING WRITTEN NOTICE TO THE PRACTICE. I MAY ALSO REQUEST IN WRITING RESTRICTIONS ON (PHI) USE AND DISCLOSURE. MY SIGNATURE ACKNOWLEDGES THAT I AM REQUESTING PAYMENT OF MEDICAL INSURANCE BENEFITS TO EITHER MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME SERVICES ARE RENDERED UNLESS OTHER FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT. MY SIGNATURE BELOW ACKNOWLEDGES THAT I AGREE TO PAY ALL REASONABLE ATTORNEY FEES AND COLLECTION COST IN THE EVENT OF DEFAULT OF PAYMENT OF MY CHARGES. MY SIGNATURE BELOW ACKNOWLEDGES MY CONSENT TO (TPI) NECESSARY FOR THE CARE OF THE ABOVE PATIENT. MY SIGNATURE BELOW CERTIFIES THAT I HAVE READ ALL OF THE ABOVE INFORMATION AND THE INFORMATION GIVEN IS TRUE.

PATIENT/GUARANTOR:_____ **DATE**_____

MEDICARE PATIENTS ONLY

MEDIGAP(MEDICARE SECONDARY PAYMENT AUTHORIZATION)

I REQUEST THAT PAYMENT OF AUTHORIZED MEDIGAP BENEFITS BE MADE ON MY BEHALF FOR ANY SERVICES FURNISHED TO ME BY ANY PHYSICIAN OF THIS GROUP. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO THE MEDIGAP PAYOR.

PATIENT SIGNATURE_____ **DATE**_____

APPOINTMENT CANCELLATION

A MINIMUM OF TWENTY-FOUR (24) HOURS NOTICE MUST BE GIVEN TO CANCEL OR RESCHEDULE AN APPOINTMENT.