

Patient Registration

UNIVERSITY ORTHOPEDICS

(Please print clearly!)

Patient Account #: _____

Patient's Name: _____ SS#: _____
First Name MI Last Name

Date of Birth: _____ Male Female Single Married Widowed Divorced Separated

Street Address: _____

City/State/Zip Code: _____ E-Mail Address: _____

Home Phone w/Area Code: _____ Cell Phone w/Area Code: _____

Patient's Employer: _____ Work Phone w/Area Code: _____

Work Address (City/State/Zip Code: _____

Spouse's Name: _____ SS #: _____

Spouse's Employer: _____ Spouse's Work Phone #: _____

Credit: MC Visa # _____ Exp ____/____/____ Name on card: _____

Responsible Party: _____ Relationship: Self Spouse Parent Other

If patient is a Minor, are parents Married Divorced Custodial Parent: _____

Custodial Parent's Home Phone w/Area Code: _____ Work Phone w/Area Code: _____

Custodial Parent's SS #: _____ Date of Birth: _____

In case of emergency, contact: _____

Phone Number w/Area Code: _____ Relationship to Patient: _____

Is this work-related? Yes No If yes, date of injury: _____ Claim #: _____

How did this injury happen? _____

Referring Physician's Name & Phone Number: _____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Insurance Company #1: _____ Phone Number: _____

>>Primary Insured's Name: _____ >>Date of Birth: _____

Policy #: _____ Group #: _____ Relationship: _____

Insurance Company #2: _____ Phone Number: _____

>>Primary Insured's Name: _____ >>Date of Birth: _____

Policy #: _____ Group #: _____ Relationship: _____

- I hereby authorize the payment of medical benefits to University Orthopedics for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
- I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.
- I hereby authorize University Orthopedics to release any medical information necessary to complete and process my insurance claims.

>> _____
>> **Patient's OR Insured's Signature** (If patient is a Minor, must have Responsible Party Signature) _____ **Date** _____

I authorize Dr. _____ to treat me and use my personal health information for healthcare operations.

>> _____
>> **Patient's OR Insured's Signature** (If patient is a Minor, must have Responsible Party Signature) _____ **Date** _____

BILLING POLICY

The following sets forth the general billing policy of University Orthopedics. Please review this information and sign where indicated.

- ❖ I understand that it is my responsibility to provide the office of University Orthopedics with current, accurate billing information at the time of check in and to notify University Orthopedics of any changes in this information.
- ❖ I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that University Orthopedics also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay. If I do not pay my co-pay at the time of my appointment, there will be an additional \$5.00 fee. If I do not cancel my appointment with a minimum of 24-hour notice, there will be a \$25.00 appointment no-show fee.
- ❖ I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a \$35.00 NSF fee. I further understand that to rectify my account, I will be required to pay with either cash, a money order, cashier's check, or credit card.
- ❖ I understand that there is a \$25.00 fee to complete disability paperwork associated with my care. Payment must be received before completed forms are released.
- ❖ I understand that University Orthopedics will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any elective surgery that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my elective surgery. I further understand that THE FEE I AM QUOTED IS AN ESTIMATE based on 1) anticipated surgery to be performed and 2) current information provided to University Orthopedics by my insurance carrier. If I do not cancel my surgery with a minimum of 24-hour notice, there will be a \$200.00 surgical no-show fee.
- ❖ I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest, or legal expenses associated with the collection efforts.
- ❖ I understand that University Orthopedics will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment and that I am responsible for any bills not paid by my insurance carrier.
- ❖ I understand that University Orthopedics may also take a verbal request to use my listed credit card for payment on my account or they may also use the same listed credit card on my account should my account become delinquent, or to cover an NSF check.

My signature below confirms that I have read these billing policies and my financial obligation as pertains to the physicians of University Orthopedics.

Legal Signature

Date

Relationship to Patient