ARTHRITIS & SPORTS

Orthopaedics • Physical Therapy • Wellness

PATIENT REGISTRATION

Please Print Clearly

Date:_____

PATIENT NAME: LAST MR. MRS. MS.	FIRST	MI	MARITAL STATUS

BILLING ADDRESS	APT #	CITY	STATE	ZIP	DATE OF BIRTH

HOME PHONE	MOBILE PHONE	AGE	SEX	SOCIAL SECURITY NO.	OCCUPATION

PERSONAL EMAIL ADDRESS (account reminders and marketing)	EMPLOYER NAME & ADDRESS

NAME OF PRIMARY INSURANCE:	SUBSCRIBER NAME (if different from above)	SOCIAL SECURITY NO.	DATE OF BIRTH Required for subscriber
_____	_____ Relationship to patient ☐ Spouse ☐Parent ☐ other:_____		

NAME OF SECONDARY INSURANCE:	SUBSCRIBER NAME (if different from above)	SOCIAL SECURITY NO.	DATE OF BIRTH Required for subscriber
_____	_____ Relationship to patient ☐ Spouse ☐Parent ☐ other:_____		

FOR WORK RELATED INJURIES

DATE OF INJURY: _____ WAS INJURY REPORTED TO SUPERVISOR? ☐ YES ☐ NO

NAME OF SUPERVISOR: _____ PHONE NUMBER _____

INSURANCE CARRIER & FULL MAILING ADDRESS:

_____ PHONE # _____ FAX # _____

_____ CLAIM # _____

_____ CONTACT PERSON _____

PLEASE ANSWER ALL QUESTIONS

Height _____ Weight: _____

Preferred Pharmacy: _____
(Include City/Location)

Family Physician: _____
Please include first and last name

Physician location: _____

ALLERGIES: _____

_____

Specific reason for seeing Orthopedic Surgeon:

_____

Symptoms began: _____

PRESENT MEDICATIONS (list all)

Name Dose Frequency Reason

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

MEDICAL RECORDS RELEASE

I authorize and request the release of my medical records to:

1-Family Physician: _____ Phone: _____ Fax: _____

2-Other Physician: _____ Phone: _____ Fax: _____

List below those individuals (family, friends, interpreter, etc.) you will allow disclosure of your personal health information from Arthritis and Sports Orthopaedics as necessary during the course of your health care services:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____

"NOTICE OF PRIVACY PRACTICES"

Acknowledgement of Receipt

By signing this page, I acknowledge having received the HIPAA notice that describes how medical information about me may be used and disclosed.

Patient Name: _____

Signature: _____

Relationship to Patient: _____ Date: _____ Witness: _____

ASSIGNMENT OF INSURANCE BENEFITS

As the patient whose name appears below, I hereby authorize Arthritis & Sports Orthopaedics, P.C. to file on my behalf for payment of any medical benefits arising out of any insurance covering me and hereby assign the benefits to Arthritis & Sports Orthopaedics, P.C. for application on the patient's bill. I certify that the information reported with regard to my insurance coverage is accurate and complete and further authorize the release of necessary information, including medical information, for this or any related claim of medical benefits. I permit a photocopy of this authorization to be used in place of the original.

I understand that I am liable for payment to Arthritis & Sports Orthopaedics, P.C. all co-insurance, co-pays, and deductibles as required by my insurance and participating agreements (if any) between the insurance carrier and Arthritis & Sports Orthopaedics, P.C. Further, I will be responsible for payment of charges not covered by my insurance plan.

Payment is expected at the time services are rendered. All professional services rendered are charged to the patient and the patient is responsible for all fees regardless of insurance carrier. Arthritis & Sports Orthopaedics, P.C. will bill charges to the patient's insurance carrier(s) and any remaining amount will be billed to the patient. Any balance due, for whatever reason, e.g. co-payments, failure to have proper referral, denial of worker's compensation benefits, patient failure to provide accurate insurance information on a timely basis, is the patient's responsibility. Amounts which are the patient's responsibility are to be paid within 30 days, and Arthritis & Sports Orthopaedics, P.C. reserves the right to increase any overdue patient balance by 20% as a late fee immediately and every 30 days thereafter. Should the patient's account be turned over to a collections agency and/or an attorney for payment due, the patient and/or guarantor shall be charged and be held responsible for an additional 30% of the principal amount in collection fees, and all attorney fees; the principal amount includes any outstanding patient balance. The patient and the guarantor agree to be responsible for and to pay interest of 18% on any unpaid balance due to Arthritis & Sports Orthopaedics, P.C. The staff of Arthritis & Sports Orthopaedics, P.C. will gladly assist you with any aspect of this policy.

Cancellation Policy (effective September 1, 2018)

If you are unable to keep your appointment we require 24-hour notice of cancellation in order to avoid $100 fee. Cancellations for Fluoroscopy injections/procedures will incur $200 fee.

_____ _____

PATIENT SIGNATURE GUARANTOR SIGNATURE (IF PATIENT IS A MINOR)