| Account #: | Dr.: | Date: |
|---|---|---|

## PATIENT INFORMATION

| First Name | Middle | Last | Birth date | Age | Sex |
|---|---|---|---|---|---|
| | | | | | |

| Street Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Home phone | Work Phone | Cell Phone | E-mail | Social Security # |
|---|---|---|---|---|
| | | | | - - |

| Occupation | Employer Name, Address |
|---|---|
| | |

| Marital Status | **Emergency Contact Name** | Relationship to Patient (circle one) | Primary Phone |
|---|---|---|---|
| | | **Spouse Mother Father Child Other** | |

| Injured on the job? | Filing Workers' Compensation? Please ask us for form. | Injured in auto accident? Please ask us for form. |
|---|---|---|
| **Y N** | **Y N** | **Y N** |

| What part of body are you here to be seen for? | Date of injury or onset (approx) | Where and how it happened (briefly, as you will explain more on other form)? |
|---|---|---|
| | | |

| Referring Physician/Friend/insurance/Attorney/ER | Primary Physician | **DRUG ALLERGIES** |
|---|---|---|
| | | |

## INDIVIDUAL RESPONSIBLE FOR PAYMENT (if different from above)

| First Name | Middle | Last | Relationship to Patient (circle one) |
|---|---|---|---|
| | | | **Self Spouse Mother Father Other** |

| Street Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Home phone | Work Phone | Employer | Social Security # |
|---|---|---|---|
| | | | - - |

| Employer address |
|---|
| |

## PRIMARY INSURANCE COMPANY

| Name | Policy ID # | Group # |
|---|---|---|
| | | |

| Street Address | City State Zip |
|---|---|
| | |

| Name of Policy Holder | Employer | Social Security # | Date of Birth | Relationship to Patient (circle one) |
|---|---|---|---|---|
| | | - - | / / | **Self Spouse Mother Father Other** |

## SECONDARY INSURANCE COMPANY

| Name | Policy ID # | Group # |
|---|---|---|
| | | |

| Street Address | City State Zip |
|---|---|
| | |

| Name of Policy Holder | Employer | Social Security # | Date of Birth | Relationship to Patient (circle one) |
|---|---|---|---|---|
| | | - - | / / | **Self Spouse Mother Father Other** |

## PATIENT AUTHORIZATION

I hereby authorize **Shady Grove Orthopaedic Associates, P.A.**, to apply for benefits on my behalf for covered services rendered by **Shady Grove Orthopaedic Associates, P.A.** I request payments are made directly to **Shady Grove Orthopaedic Associates, P.A.** from my insurance carrier to include Medicare benefits. I also authorize the release of information acquired during the course of my examination and treatment to the Health Care Financing Administration and its agents, or any other third-party carrier as necessary to secure payment of any benefits due me.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical for this or any related claim in order to determine benefits to which I may be entitled. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

**ALL CO-PAYS ARE DUE AND PAYABLE AT THE TIME OF SERVICE**

THERE IS A $25.00 FEE FOR ALL RETURNED CHECKS

Signature:________________________________________

(Relationship to Patient: Self/Spouse/Mother/Father/Other __________) Date:

## FINANCIAL RESPONSIBILITY AGREEMENT

I will be financially responsible for the medical expenses for my visit(s) to **Shady Grove Orthopaedic Associates, P.A.** if my insurance eligibility cannot be verified at the time of my visit, and/or if it is determined by my insurance company that the services provided is not a covered benefit. When I am billed for these services and I do not make payment in full or arrange with the business manager to make payments in a timely manner then I understand that my account will be reviewed to be placed in a collection agency. Court costs and reasonable collection fees could be added to my balance. I also understand that nonpayment could result in my account being reported to the credit bureau.

Failure to comply with the above requirement means that I voluntarily terminate my care with the **Shady Grove Orthopaedic Associates, P.A.** and I will seek further care for my orthopaedic problem with another practice.

Signature:______________________________ Date: Witness:______________________
(Relationship to Patient: Self/Spouse/Mother/Father/Other_____)

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## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that **Shady Grove Orthopaedic Associates, P.A.** has provided you access to a copy of its Privacy Notice, which explains how your health information will be handled in various situations. By law, we are required to have you sign this form on your first date of the service with us.

If your first date of service with us was due to an emergency, we must try to provide you access to this Notice and have you sign this form as soon as we can after the emergency.

Please specify by checking the appropriate answer below if we may leave health-related information (e.g. lab/x-ray results, billing issues, or other doctor-patient communications) on your:

| | | |
|---|---|---|
| Home voicemail (please circle) ---------------------------------------- | **Yes** | **No** |
| Work voicemail (please circle) ---------------------------------------- | **Yes** | **No** |
| Personal e-mail:______________________________ | **Yes** | **No** |

| If you are unavailable, who is authorized to receive this information? | Relationship (circle one)<br>**Spouse Child Parent Other:** ____________ |
|---|---|

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(Please note that if the above section is not completed, we will assume that we have your approval to contact you using any of these methods.)

**[ ] Shady Grove Orthopaedic Associates, P.A. has provided me access to its Privacy Notice. I understand I may request a copy for my personal use.**

**I acknowledge that I have read, understand and agree to the above.**

Signature:________________________________________________ Date:

**Office use only** if Acknowledgement Form is ***not*** signed:

1. Does the patient have a copy of the privacy notice? **Yes No**
2. Please explain why the patient was unable to sign an Acknowledgement Form and the Practice's efforts in trying to obtain the patient's signature:

Employee's Initials:________________________________________ Date:

**I CERTIFY THAT THERE ARE NO CHANGES CONCERNING MY NAME/ADDRESS/CONTACT NOS. AND HEALTH INSURANCE AS OF ____________. ________________________________________**
**(MM/DD/YYYY) (PATIENT'S FULL NAME AND SIGNATURE)**

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**Office use only**

Initiated by:________________________________________ Date: