

ORTHOPAEDIC SPECIALISTS / HAND SURGICAL ASSOCIATES

Patient Information (please print)

Date: _____

First Name: _____ **M.I.** _____ **Last Name** _____ **Suffix** _____

Sex: M F **Status:** single married other **Date of Birth:** _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ - _____

Social Security # _____ **Email:** _____

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

Emergency Contact: _____ **Relationship:** _____

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

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Guarantor: (person responsible for payment of services not covered by health insurance if different than patient)

Name: _____ **Date of Birth:** _____ **Relationship:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

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

.....
Employer: _____ **Phone:** _____ **Occupation:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

.....
 Family Physician **Referring Physician** **Specialty:** _____

Name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

.....
 Auto Injury **Work Injury**

Insurance Company Name: _____ **Claim #:** _____

Date of Injury: _____ **Adjuster Name:** _____ **Phone:** _____

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Student/Athlete Information **Name of School:** _____

Sport: _____ **Date of Injury:** _____

Home Address: _____ **Phone:** _____

Local Address: _____ **Phone:** _____

Father's Name: _____ **Date of Birth:** _____

Mother's Name: _____ **Date of Birth:** _____

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Signature on File: I hereby authorize Orthopaedic Specialists, P.C. to release information necessary to file a claim with my insurance company. I also authorize Orthopaedic Specialists, P.C. to submit a claim to my insurance carrier or its intermediaries for all covered services rendered and direct my insurance carrier or its intermediaries to issue payment directly to Orthopaedic Specialists, P.C. or the individual physician indicated on the claim form.

I understand that I am financially responsible for any balance not covered by my insurance carrier.
Effective 08/01/2011: Checks returned by your bank are subject to a \$25.00 processing charge and if your account is referred for collection, you will be responsible for: collection costs in the amount of 33.33% of the outstanding balance, court costs and reasonable attorney's fees.

I hereby consent to and authorize the performance of medical treatment and/or procedures by the physicians and others (nurses, physician assistants, x-ray technologists, and therapists) of Orthopaedic Specialists, P.C.

Medicare Patients I request that payment of authorized Medicare benefits be made either to me or on my behalf to Orthopaedic Specialists, P.C. for any services furnished to me by Orthopaedic Specialists, P.C. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related service. I authorize any holder of Medicare information about me to release to my Medicare Supplemental Insurance Carrier any information needed to determine their benefits payable for related services.

I hereby acknowledge receipt of Orthopaedic Specialists, P.C./Hand Surgical Associates notice of privacy practices.

Signature (Patient or Legal Guardian): _____ **Date:** _____