Patient Profile

Doctor _____

PATIENT INFORMATION

Name: _____ **Patient ID #:** _____ **Sex** [ ]M [ ]F

Address: _____ **Date of Birth:** _____

_____ **Social Security #:** _____

City,State _____ **Marital Status:** [ ]Married [ ]Single [ ]Divorced

Phone: _____ [ ]Home [ ]Work [ ]Other **Referring Physican:** _____

Phone: _____ [ ]Home [ ]Work [ ]Other **Primary Physician:** _____

PATIENT EMPLOYMENT

[ ]Employed [ ]Retired [ ]Unemployed [X]Other

Phone: _____

Employer: _____

ALTERNATE

_____

_____

_____

GUARANTOR

[ ]Same as Patient

Name: _____

Address _____

_____

City,State: _____

EMPLOYMENT

Employer: _____

Phone: _____

Phone: _____

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: _____ **Relationship to Patient:** _____

Insured Phone: _____ **Social Security #:** _____

Company: _____ **Insured ID:** _____

Policy Group: _____

Date of Birth: _____

DATE OF INJURY :

SECONDARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: _____ **Relationship to** _____

Insured Phone: _____ **Social Security #:** _____

Company: _____ **Insured ID:** _____

Policy Group: _____

Date of Birth: _____

MEDICARE SIGNATURE ON FILE

I request that payment of the authorized Medicare benefits be made on my behalf to **South County Orthopedic Specialists** for any services furnished me by the listed provider/supplier. 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 or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other charge approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the **patient is responsible only for the deductible, co-insurance and non-covered services.** Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____ _____

Patient's Name (Please Print) Patient's Signature Date

MEDIGAP ASSIGNMENT OF BENEFITS

I request that payment of authorized Medigap benefits be made either to me or on my behalf to South County Orthopedic Specialists for any services furnished by the listed provider/supplier. I authorize any holder of medical information about me to release to the Medigap insurer any information needed to determine these benefits payable for related services.

_____ _____ _____

Patient's Name (Please Print) Patient's Signature Date

If unable to keep appointment, kindly give 24 hours notice during office hours. A charge may be applied for any uncancelled appointments.

In the case of a third party liability injury, we do not correspond with any attorneys, nor do we appear in court on your behalf. You may request to have your medical records copied by a copy service, which we will be happy to arrange for you. You will be responsible for the copy service fees. There is an additional charge to have X-rays copied. If your insurance requires that insurance forms be completed by us or your medical records copied and sent to them, there is a nominal charge for this service, which will be added to your account.

PATIENT'S INSURANCE AUTHORIZATION

I hereby authorize the processing of the medical insurance either by electronic or manual method by the listed facility. My signature authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer to pay the listed provider assignee. I further authorize assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any co-insurance or deductible, and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original.

Payment in full is required at the time of service, for your convenience, we accept personal checks, Visa/Mastercard, as well as cash. Any insurance coverage which you may have is intended to protect you against financial loss, not as payment in full for your care. Payment in full for your care is your responsibility and may not be postponed until the time your insurance reimburses you. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original.

Treatment Authorization: I authorize the treatment by **South County Orthopedic Specialists**. I have read the above paragraph regarding payment of fees, and I understand that I am solely responsible for all charges incurred, regardless of insurance coverage or liability of another party. I will make sure that my claims are paid promptly.

_____ _____ _____

Patient's Name (Please Print) Signature of Patient/Guardian Date

TREATMENT OF A MINOR

I authorize **South County Orthopedic Specialists** to treat a minor.

_____ (minor)

_____ _____

Signature of Patient/Guardian Date