

PATIENT INFORMATION



DATE: / /
MM/DD/YYYY

NAME – LAST		FIRST		MIDDLE	NAME YOU GO BY	
SOCIAL SECURITY # - -		SEX	MARITAL STATUS	RACE	AGE	DATE OF BIRTH
ADDRESS			CITY	STATE & ZIP		COUNTY
HOME PHONE ()	WORK PHONE ()	CELL PHONE ()		E-MAIL ADDRESS		
SPOUSE'S NAME		ADDRESS IF DIFFERENT THAN YOURS			PHONE ()	
EMERGENCY CONTACT NAME & PHONE NUMBER				RELATIONSHIP TO PATIENT		
RESPONSIBLE PARTY IF PATIENT IS CHILD/STUDENT		SOCIAL SECURITY # - -		DOB	PHONE ()	
EMPLOYER NAME (IF SELF-EMPLOYED, NAME OF BUSINESS)			EMPLOYER CONTACT NAME		PHONE ()	
EMPLOYERS ADDRESS			CITY	STATE & ZIP		

PRIMARY INS.		POLICYHOLDER		SOCIAL SECURITY # - -		DATE OF BIRTH
SECONDARY INS.		POLICYHOLDER		SOCIAL SECURITY # - -		DATE OF BIRTH
MEDICARE #		MEDICAID #		SELF PAY YES NO		LIABILITY YES NO
WORK COMP YES NO	IF YES, IS THIS APPROVED? YES NO		DATE OF INJURY		STATE INJURY OCCURRED(Example-Missouri)	
REFERRING PHYSICIAN OR PERSON			FAMILY PHYSICIAN			

FINANCIAL ARRANGEMENTS

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. All charges are your responsibility from the date the services were rendered. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact one of our account supervisors regarding the management of your account. If you have any questions or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance and any other health plans to *Orthopaedic Specialists of Springfield, P.C.*

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as any original. I understand that I am financially responsible for all charges whether or not paid by insurance. If the charges are not paid and no other arrangements are made for payment and it is necessary to send the account to a collection agency or an attorney, I promise to be responsible for all costs of collection and reasonable attorney fees. I understand that any and all information may be released (including substance abuse information if applicable) to secure payment and/or at the request of any other party at my request or authorization. The undersigned further acknowledges that the practice of medicine is not an exact science and that the physicians of *Orthopaedic Specialists of Springfield, P.C.* do not and will not make any warranties or guarantees concerning any care or treatment to be provided.

As a patient you have certain responsibilities for your care. Those responsibilities include: 1) Providing current, accurate billing information at all visits. 2) Provide physician with complete medical history. 3) Being aware of which benefits your insurance does and does not cover. 4) Failure to cancel appointments 24 hours in advance may result in a fee.

I hereby authorize my insurance benefits to be paid directly to *Orthopaedic Specialists of Springfield, P.C.* and I am financially responsible for any balance due. I authorize *Orthopaedic Specialists of Springfield, P.C.* to release any information necessary to process an insurance claim including industrial injury.

My signature acknowledges understanding and consent of all of the above information.

SIGNATURE: _____ **DATE:** _____

Patient OR Parent/Guardian if signing for a minor