

Patient Registration

Patient Information

Patient's Name _____

Mailing Address _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Patient's Employer _____

Birthdate _____ Marital Status _____

Male/Female _____ Social Security Number: _____

Primary Care Physician _____

Primary Care Physician Phone _____

Emergency Contact Name _____

Emergency Contact Phone _____

Primary Insurance

Name of Insurance Company _____

Policyholder _____

PT Relationship to Policyholder _____ ID or Claim Number _____

Group Number _____

Insurance Company Address _____

Policyholder's Birth date _____ Gender _____ Work Phone _____

Policyholder Social Security Number _____ Employer _____

Secondary Insurance

Name of Insurance Company _____

Policyholder _____

PT Relationship to Policyholder _____ ID or Claim Number _____

Group Number _____

Insurance Company Address _____

Policyholder's Birth date _____ Gender _____ Work Phone _____

Policyholder Social Security Number _____ Employer _____

If involved in an auto accident, are you in litigation? Yes _____ No _____

Attorney Name _____ Phone Number _____

Attorney Address _____

Private Accounts

The office Specialty Orthopedic Center, LLC will file insurance claims on your behalf if you present your insurance card(s) at the time of your appointment. Exceptions to this policy include out of state Medicaid. Payment of your co-insurance, as defined by your insurance carrier, is required at the time of service. If your insurance company requires a referral/authorization this MUST be made PRIOR to your visit. Patients without prior authorization from the PCP will be asked to pay in full at time of service. Uninsured patients are required to pay in full for services rendered at the time of appointment. The offices of Specialty Orthopedic Center, LLC will not be responsible for negotiating a settlement or disputed claim with your insurance company.

Liability Accounts

When you have been involved in an accident, your health insurance may be filed, provided they make payment without waiting for all other involved insurances to be exhausted. Premises medical coverage may pay your medical bills as they are incurred if you were injured on the property of a business or homeowner. This information must be supplied at the time of your appointment. If auto, health, or premises medical insurance coverage information is not available, you will be given the necessary forms to file your own claim; however, payment in full will be required at the time services are rendered.

Authorization

Prior to your visit, your employer's worker's compensation carrier must call this office to establish your injury or occupational disease as a recognized work-related problem. Without this verification, you will be responsible for payment of your account. Laws governing work-related injuries require your physician to submit a report of your progress following each visit to your employer, insurer, and/or rehabilitation representative. In the event the employer or insurer denies you verification, your claim can be filed with your private health insurance, and as a private account, co-payment would be expected at time of visit. If you have any questions, please contact our office at 561-826-2000.

My signature below represents that I have read and understand these policies of the office of Specialty Orthopedic Center, LLC. I also agree to make available information required and necessary for Specialty Orthopedic Center, LLC to file insurance claims on my behalf, and that ultimately, I am responsible for my account, and failure to make payment on a timely basis may result in collection actions.

(Signature) (Date)

Authorization to release information and pay benefits to physicians (lifetime form)

I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf to Specialty Orthopedic Center, LLC for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and/or their insurance companies and its agents any information needed to determine these benefits payable for related services.

(Signature) (Date)

I authorize the release of complete medical information to my referring physician.

I authorize the release of complete medical information to any physician or other health care provider to whom I am referred by my physician.

(Signature) (Date)