



*Total Joint Replacement, Spine Surgery, General Orthopaedics, Sports Medicine, Arthroscopic Surgery*

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
(LAST) (FIRST) (MI)

STREET ADDRESS: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

NORTHERN ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ RACE: \_\_\_\_\_ SEX: \_\_\_\_\_ SS#: \_\_\_\_\_

MARITAL STATUS:  MARRIED  SINGLE  WIDOWED  DIVORCED

PLACE OF EMPLOYMENT: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

SPOUSES NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SPOUSES SOCIAL SECURITY NUMBER: \_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

NAME OF NEAREST RELATIVE: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_  
(OTHER THAN SPOUSE)

ADDRESS: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PERSON RESPONSIBLE FOR BILL: \_\_\_\_\_

IN CASE OF EMERGENCY, CONTACT: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

ARE YOU UNDER MEDICARE?  YES  NO NUMBER: \_\_\_\_\_

IF "YES", DO YOU CARRY SUPPLEMENTAL INSURANCE:  YES  NO

INSURANCE COMPANY NAME: \_\_\_\_\_

DO YOU HAVE MEDICAL INSURANCE:  YES  NO

IF "YES" COMPANY NAME: \_\_\_\_\_

POLICY #: \_\_\_\_\_ IDENTIFICATION: \_\_\_\_\_ GROUP #: \_\_\_\_\_

WHO REFERRED YOU TO US: \_\_\_\_\_

DO YOU HAVE ANY ALLERGIES:  YES  NO

IF "YES", LIST THEM: \_\_\_\_\_

IT IS OUR POLICY THAT ALL OFFICE VISITS AND OFFICE SERVICES BE PAID FOR AT THE TIME THESE SERVICES

ARE RENDERED. YOU WILL BE PAYING BY:  CHECK  CASH  OTHER:

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED, WHETHER OR NOT THEY ARE PAID FOR OR SUPPLEMENTED BY AN INSURANCE COMPANY.

New Beneficiary Signature Regulations in effect since April 1, 1992, allow physicians (or other suppliers in most cases) to obtain from the beneficiary and retain in their files, a lifetime signature authorization for the physician or supplier to submit assigned or unassigned claims in the beneficiary's behalf.

The beneficiary must sign a brief statement substantially as follows:

"I request that payment for authorized Medicare benefits and any other insurance benefits be made either to me or on my behalf to (name of physician or supplier) for any services furnished me by that physician/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 those benefits or the benefits payable for related service".

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE

## **FINANCIAL POLICY**

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

### **REGARDING INSURANCE**

**MEDICARE** – We accept Medicare assignment. This means that we have agreed in contract to accept the fees and bill according to Medicare allowed amount. The patient is responsible for the annual deductible and 20% of the approved amount at the time of service except when there is a supplemental policy to pay these amounts.

**MEDICAID** – We accept Medicaid with proof of eligibility. The patient is responsible for the \$2.00 co-payment at the time of service. This does not apply to Medicaid recipients who are under 21 years old, or those recipients who are also receiving Medicare benefits. Regarding the Share of Cost Program – It is our policy that the patient will be responsible for any charged incurred unless proof is provided stating that the Share of Cost amount has been met. If at a later date the patient becomes eligible for coverage of a previous date of service, any monies paid to use will be refunded.

**PRIVATE INSURANCE** – We may accept assignment of insurance benefits after your deductible has been met. All co-pays and deductibles are due at the time of service. If in the event your insurance company has not paid your account in full within 45 days, we require that you establish an extended payment plan or provide a credit card with authorization to bill that account for the balance. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance policy contract.

If you do not fall within any of the categories above we require **FULL PAYMENT AT THE TIME OF SERVICE.**

For your convenience we accept **CASH, CHECKS, AND CREDIT CARD.** If necessary, and if you qualify, **WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.**

### **USUAL AND CUSTOMARY RATES**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

**X** \_\_\_\_\_ DATE \_\_\_\_\_  
Signature of Patient or Responsible Party