Mark Provenzano M.D.
Carl Palumbo M.D.
Juan Bustos M.D.
Neil Badlani M.D.

PATIENT FINANCIAL RESPONSIBILITY

I understand that The Orthpedic Sports Clinic will file a claim on my behalf to my insurance company. I realize this is done as a courtesy to patients. Regardless of insurance company response I acknowledge that I am responsible for payment in full for services rendered.
My insurance is a contract between my employer, the insurance company, and me. The Orthopedic Sports Clinic is not part of that contract
I authorize my insurance benefits to be paid directly to the Orthopedic Sports Clinic, realizing I am responsible for payment as stated above

Date: _____ **Signature:** _____

MEDICAL RECORD RELEASE

I authorize The Orthopedic Sports Clinic to release medical information pertaining to my claim to my insurance company, third party payer and/or my attorney. There is a fee for copying medical records.

Date: _____ **Signature:** _____

PRIVACY PRACTICES

I am aware that The Orthopedic Sports Clinic has a copy of their privacy practices on file. I am aware that these privacy practices are available to me upon request.

Date: _____ **Signature:** _____

The Orthopedic Sports Clinic

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Date:_____

Was Injury the result of an auto accident? **Yes / No** Was Injury work/job related? **Yes / No**

Patient Name: _____ Sex: M / F

Birth Date:_____/_____/_____ Age: _____ SSN: _____ - _____ - _____

Height: _____ Weight: _____ Current Medications: _____

_____

Marital Status: Single / Married / Life Partner / Divorced / Widowed / Student

Patient Home Address: _____ZIP: _____

Home #: ( ) _____ Work #: ( ) _____ Cell #: ( ) _____

Emergency Contact: _____ Emergency Phone #: ( ) _____

Patient Employer: _____ Occupation:_____

Best Contact Email Address: _____

Insurance Company Name: _____ Subscriber Name:_____

Date of Birth: _____/_____/_____ SSN: _____- _____ - _____ Relationship to Patient: _____

Referred By: _____

950 Campbell Road · Houston, Texas 77024
Tel. 713.464.0077 · Fax 713.464.9582 ·www.orthopedicsports.com