PATIENT FINANCIAL RESPONSIBILITY

I understand that The Orthopedic 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: ___________________________
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: ___________________________