

SOUTHERN ORTHOPEDICS AND SPORTS MEDICINE
PATIENT REGISTRATION FORM
(Please Print Clearly)

Date: _____

Patients Full Name: _____

(Last) (First) (Middle) (Maiden)
Date of Birth: _____ Social Security # _____ Marital Status: S M W D

Address: _____ Race _____ Language _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____ Alt. Phone: _____

Employer: _____ Phone: _____

Address: _____

Spouse's Name: _____ Date of Birth: _____ Social Sec#: _____

Employer: _____ Phone: _____

Family Physician: _____ Referring Physician: _____

Complete below for patients under 18 and/or covered by the parents insurance:

Father's Full Name: _____ Date of Birth _____ SS # _____

Address (if different from child): _____

Home Ph: _____ Employer: _____ Emp. Ph: _____

Mother's Full Name: _____ Date of Birth: _____ SS# _____

Address: (if different from child) _____

City: _____ State: _____ Zip code: _____

Home #: _____ Employer: _____ Emp. Ph: _____

INSURANCE INFORMATION: COMPLETE ONLY IF YOU DO NOT HAVE A CURRENT COPY OF YOUR INSURANCE CARD AND BE SURE TO NOTIFY US IF YOUR INSURANCE HAS CHANGED.

Primary Insurance: _____ Effective Date: _____

Member's Name (Policy Holder): _____

Policy holder Social Security #: _____ Policy holder Date of Birth: _____

Member ID #: _____ Group #: _____ Employer: _____

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Secondary Insurance: _____ Effective Date: _____

Member's Name (Policy Holder): _____

Policy holder Social Security #: _____ Policy holder Date of Birth: _____

Member ID #: _____ Group #: _____ Employer: _____

How did you hear about us? (Please check all that apply)

Insurance _____ Work _____ Patient _____ Radio _____ Mailer _____

Family _____ Hospital _____ Physician _____ Friend _____ Newspaper _____

Yellow Pages _____

The Health Professionals and staff of Southern Orthopedics and Sports Medicine, LLC are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of legal duties and privacy practices with respect to your Protected Health Information. When the Health Professionals and staff use or disclose your Protected Health Information, the Health Professionals and staff are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure). Your PHI may be used and disclosed to provide treatment and other services to you—for example, to diagnose and treat your injury or illness. In addition, you may be contacted to provide you appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your PHI may be disclosed to other providers involved in your treatment.

I have read and understand the terms of this Notice and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Southern Orthopedics and Sports Medicine to use or disclose my health information in the manner described above.

Signature of Patient

Date

Please list anyone in your family, other than yourself, that we may disclose your PHI or appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your PHI may be disclosed to the below person(s).

Name of Authorized Person

Relationship to Patient

Date

Name of Authorized Person

Relationship to Patient

Date

Name of Authorized Person

Relationship to Patient

Date

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ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to Southern Orthopedics and Sports Medicine all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the office to release all information to secure the payment of benefits. I authorize the use of my signature on all insurance submissions whether manual or electronic.

I further authorize Southern Orthopedics and Sports Medicine to disclose information in my medical records, including current and previous medical records, to other physicians and health care providers to whom the physician refers me for my treatment.

Financial Agreement

I acknowledge that payment is due at time of treatment and I agree that Parents/Guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full responsibility for all charges not covered by insurance.

Signature: _____ Date: _____

Print: _____

Relationship to Patient: _____

Witness: _____ Date: _____

MINOR CHILD CONSENT

I, being the parent/guardian of _____ do hereby request and authorize Southern Orthopedics and Sports Medicine and staff to perform necessary services for my child, including but not limited to x-rays, labs and administration of medications and anesthetics which are deemed advisable by the physician.

Signature: _____ Date: _____

Print: _____

Relationship to Patient: _____

Witness: _____ Date: _____

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Form: 11/14/08

Office Financial Policy

We are happy that you selected Southern Orthopedics and Sports Medicine for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

Patients are financially responsible for all services provided and are expected to pay for services received on the same date that services are rendered. Patients are also responsible for any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship.

Medicare

The office will bill the Medicare intermediary. Patients are responsible for the following:

- \$124 annual Medicare Part B deductible
- 20% co-pay of the allowed charge
- any non-covered services
- any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN).

Medicare Supplemental

The office will bill both Medicare and secondary insurances.

Medicaid

Medicaid patients are to provide the clinic with a **current Medicaid card** with every visit. Medicaid patients are responsible for **all non-covered services**. Medicaid patients are responsible for applicable co-pays. Medicaid patients are responsible for securing necessary referrals from primary care physicians.

HMOs and PPOs

Patients are responsible for payment of the co-pay and deductible at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. If the patient is not prepared to pay the co-pay or deductible, the medical assistant or nurse will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

Commercial Insurance

Patients are responsible for any **co-pay, deductible, or non-covered amounts**. **Insurance is billed as a courtesy**. Patients are responsible for the **balance in full** if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, the medical assistant or nurse will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

Self-Pay

Patients are responsible for payment in full at the time of services for all services rendered.

Worker's Compensation

Patients are not responsible for any charges unless the workers compensation case has been dismissed or denied.

Personal Injury/Motor Vehicle Accidents

The patient is responsible for the balance in full at the time of service. Any settlement you receive from your insurance company will be handled by you, your insurance company, and/or your attorney.

Managed Care

If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out-of-state or out-of-network benefits. The patient will either be required to make payment in full or pay any co-pay or deductible.

I understand the above policy and acknowledge that I am financially responsible for services rendered.

Patient or Parent/Guardian

Date

Revised-11/14/08