

ROME ORTHOPAEDIC CLINIC

PLEASE COMPLETE ALL AREAS AND SIGN THE BACK OF THE FORM

Patient's Full Legal Name: _____ Date: ___/___/___

Home Address: _____

City, State, Zip Code: _____

Home Phone: () _____ Birthdate: ___/___/___ Drivers License # _____

Work Phone: () _____ Employer: _____

Cellphone: () _____ Social Security #: ____-____-____ Sex: M or F

Referred by: _____ Primary Physician: _____

Marital Status: S M D W Student?: Yes or No

Emergency Contact: _____ Phone: () _____

Workers' Compensation Injury: Yes or No If yes, date of injury: ___/___/___

Automobile Injury: Yes or No If yes, date of injury: ___/___/___

Responsible Party: (Please complete if patient is a child, student, or if you have power of attorney)

Name: _____ Social Security # ____-____-____

Address: _____

City, State, Zip Code: _____ Employer: _____

Relationship to Patient: _____

Primary Insurance: (Please present insurance cards to receptionist)

Name: _____ Address: _____

City, State, Zip Code: _____ Phone #: () _____

Group# _____ Policy or ID # _____

Name of Insured: _____ SS# of insured: ____-____-____

Birthdate of Insured: ___/___/___ Relationship of Patient to Insured: _____

Insured's Employer: _____

Secondary Insurance: _____

Address: _____

City, State, Zip Code: _____ Phone: () _____

Group # _____ Policy or ID # _____

Name of Insured: _____ SS# of Insured: _____ - _____ - _____

Birthdate of Insured: ____/____/____ Relationship to Insured: _____

It is your responsibility to pay any amount not covered by your insurance(s). Co-pays, deductibles, and co-insurance amounts are payable before service is rendered.

If your account is not settled in a timely manner, we reserve the right to place the account with an outside collection agency. We are entitled to recover in full from the patient or responsible party all court costs, attorney fees, collection agency fees, and pre and post judgment interest at the current legal rate.

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I hereby assign all medical and/or surgical benefits under the terms of my insurance or legal award to: Rome Orthopaedic Clinic. I hereby authorize Rome Orthopaedic Clinic to release and disclose information necessary to any party in order to determine liability for payment and/or to secure reimbursement. I authorize Rome Orthopaedic Clinic to release information regarding my medical condition to my insurance company and any health care professional or individual involved in my medical care.

This assignment and authorization will remain in effect until revoked by me in writing. A photocopy of this assignment and authorization is considered to be as valid as the original. I understand that I am personally responsible for the payment of all charges that occur as a result of my medical treatment and I agree to pay all charges including those not covered by insurance.

I authorize Rome Orthopaedic Clinic to bill Medigap covered services.

I authorize Rome Orthopaedic Clinic or their representative to take clinical pictures of me, to be kept as part of my medical record. I agree and give my consent to all procedures and treatment that the physician or physician extenders perform or request.

_____ Date: ____/____/____
Signature of Patient or Guardian

MEDICARE LIFETIME AUTHORIZATION

I authorize any holder of medical or other information about me to release to the CMS, its intermediaries or carriers, any information needed for this or any Medicare related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ Date: ____/____/____
Signature of Patient or Guardian

I HAVE READ THE ENTIRE CONTENTS OF THIS FORM, AND UNDERSTAND ITS MEANING.

_____ Date: ____/____/____
Signature of Patient or Guardian