

MID COUNTY ORTHOPAEDIC SURGERY AND SPORTS MEDICINE

David J. Anderson, M.D.
 Craig E. Aubuchon, M.D.
 George S. Bassett, M.D.
 Michael F. Burns, M.D.
 Lukasz J. Curylo, M.D.
 Thomas J. Fox, M.D.
 Colleen E. Glisson, M.D.
 Thomas F. Lieb, M.D.
 Laura L. Meyers, M.D.

Joshua P. Nadaud, M.D.
 Stephanie A. Otis, M.D.
 Jason D. Rabenold, M.D.
 Preeti S. Shastri, M.D.
 Daniel G. Sohn, M.D.
 Enrico J. Stazzone, M.D.
 David W. Strege, M.D.
 Jesse G. Susi, M.D.
 John E. Tessier, M.D.
 Kenneth W. Zehnder, M.D.

REFERRED TO THIS OFFICE BY:

- Patient (Name) _____
 Doctor (Name) _____
 ER (Hospital) _____

Date: _____

PATIENT REGISTRATION

- New Patient
 Update

Patient's Email _____

Patient's Last Name _____ First _____ Middle _____ Date of Birth _____ Age _____ Sex M/F

SSN # _____ Marital Status _____ Spouse's Name _____ Home Phone # (____) _____

Patient's Address _____ Street _____ City/State _____ Zip _____ Work Phone # (____) _____ Cell Phone # (____) _____

Patient's Employer _____ Employer's Address _____

PARTY RESPONSIBLE FOR BILL (AND SPOUSE) IF OTHER THAN PATIENT

Both Parents, if patient is a minor (under 21)

Last Name _____ First _____ Middle _____ Relationship to Patient _____ SSN # _____ Date of Birth _____

Address _____ Street _____ City/State _____ Zip _____ Phone (____) _____

Employer's Name _____ Employer's Address _____ City & State _____ Phone (____) _____

Last Name _____ First _____ Middle _____ Relationship to Patient _____ SSN # _____ Date of Birth _____

Address _____ Street _____ City/State _____ Zip _____ Phone (____) _____

Employer's Name _____ Employer's Address _____ City & State _____ Phone (____) _____

INSURANCE INFORMATION: PLEASE HAVE INSURANCE CARD(S) AVAILABLE TO COPY

Primary Insurance Co. _____ Effective Date _____

ID # _____ Group # _____

Subscriber _____ First _____ Middle _____ Last _____ Subscriber SSN # _____ Date of Birth _____

Secondary Insurance Co. _____ Effective Date _____

ID # _____ Group # _____

Subscriber _____ First _____ Middle _____ Last _____ Subscriber SSN # _____ Date of Birth _____

Other Insurance Co. _____ Effective Date _____

ID # _____ Group # _____

Subscriber _____ First _____ Middle _____ Last _____ Subscriber SSN # _____ Date of Birth _____

INJURY REPORT/NATURE OF INJURY

- WORKER'S COMP RECREATIONAL AUTO HOME OTHER
 DATE OF INJURY _____

MID-COUNTY ORTHOPAEDIC SURGERY & SPORTS MEDICINE
PATIENT CONSENT FORM

PATIENT NAME _____
LAST FIRST MIDDLE INITIAL

SSN _____

1. RELEASE OF INFORMATION:

I authorize my physician to release any medical information concerning my care, including copies of medical records, and/or billing information pertaining to my medical care to individuals or representatives of agencies or organizations in connection with obtaining payment of the medical services rendered to me.

I acknowledge that this authorization has no expiration date and is valid to authorize the release of medical records and billing information.

2. ASSIGNMENT OF INSURANCE BENEFITS:

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by Mid-County Orthopaedic Surgery & Sports Medicine, I hereby irrevocably transfer said physicians all insurance benefits now due and payable to me or to become due and payable to me under any insurance policy or policies, or any replacement policies thereof that might be applicable.

I authorize direct payment by any insurance company to Signature Health Services, Mid County Orthopaedic Surgery and Sports Medicine. I understand that my obligation to pay all charges is not affected by the fact that I have insurance benefits, and if my insurance company fails to pay all or any portion of these charges for any reason, I will be responsible for all sums due and owing.

3. GUARANTEE OF ACCOUNT:

In consideration of any and all medical services rendered to the above named patient, I agree to pay Mid-County Orthopaedic Surgery & Sports Medicine the charges for all services ordered by physician. If I have not followed the requirements for referral, second opinions, or pre-certification of my care, as outlined by my insurance carrier, I understand that I will be responsible for all charges that I incur. In the event of nonpayment, I will be responsible for any legal or collection fees. The collection fee is a percentage of the total balance turned over to an outside agency. I agree to be responsible for these fees.

4. MEDICARE INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to Healthcare Financing Administrator or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I understand I am responsible for the Part B deductible for each year, the remaining Co-Insurance and any other amounts which may become due.

The patient or patient's representative certifies that he/she has read and accepted the above, where applicable to the patient's condition and status, and further certifies that he/she is the patient, or is duly authorized on behalf of the patient to execute such an agreement.

5. ACKNOWLEDGEMENT OF PRIVACY NOTICE:

I have been provided with a Notice of Privacy Practices that describes the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail or provide a copy of any revised notice.

Patient's Signature/Person Authorized to Consent (Relationship) DATE _____

Guarantor of Account if other than Patient (Relationship) DATE _____

I hereby certify that I have witnessed the signature of the patient and/or individual signing on behalf or for the benefit of the patient.

Date Witness