

STEAMBOAT ORTHOPAEDIC ASSOCIATES, P.C.

Referring Doctor: _____

Today's Date: _____

PATIENT INFORMATION FORM:

Name: _____ Age: _____ Date of Birth: _____
Last First M.I.

Street Address: _____
Street Apt # City State Zip

Mailing Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient Social Security#: _____ Sex: Male Female

Marital Status: Single Married Separated Divorced Widowed Spouse Name: _____

Patient Employer: _____ Occupation: _____

Employer Address: _____
Street City State Zip

Emergency Contact: _____ Relationship: _____ Phone: _____

FINANCIALLY RESPONSIBLE PARTY IF DIFFERENT FROM PATIENT (PARENT/INSURANCE POLICY HOLDER):

Parent/Subscriber's Name: _____ Subscriber's DOB: _____ Relationship: _____

Address (if different): _____
Street City State Zip

Subscriber's Employer: _____ Subscriber's SS#: _____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize and request my insurance company to pay directly to the doctor the amount due on my claim for services rendered to me or my dependent. I further agree that should the payment be insufficient to cover the entire medical and surgical expense, I will be responsible for payment of the difference, and if the nature of the injury/disability is such that it is not covered by the policy, I will be responsible to the doctor for payment of the entire bill.

Signature of Patient or Guardian: _____

NOTICE TO PATIENT

We bill insurance as a courtesy to you. Some insurance companies and managed care companies require written referrals or authorization from the insurance company before obtaining care from a specialist. It is the patient's responsibility to obtain any necessary referrals. Ultimately, the bill is your responsibility.

RELEASE OF MEDICAL INFORMATION FOR INSURANCE AND TREATMENT PURPOSES:

I hereby authorize the release of any information, including medical diagnoses and the records of any treatments or examination rendered, to my insurance company or companies and/or to other health care providers as deemed necessary to coordinate my treatment. This release is solely for the purpose of facilitating the billing and reimbursement of my medical bill and for management of my health care. I understand that by signing below I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations on my behalf. I also acknowledge receipt of SOA's HIPAA information pamphlet.

Signature of Patient or Guardian: _____