

PATIENT INFORMATION
PLEASE PRINT



www.alabamaorthocenter.com

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

E-Mail Address: _____ SS #: _____ Age: _____

Primary Pharmacy Name: _____ Primary Pharmacy Ph #: _____

Sex: _____ Race: _____ Date of Birth: _____ Primary Care Physician: _____

Who referred you to Alabama Orthopaedic Center? _____

Employed By: _____

Name of person responsible for bill: _____

Address: _____

Relation to Patient: _____ SS #: _____ Date of Birth: _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Employed By: _____

Primary Insurance _____ **Secondary Insurance** _____ **Tertiary Insurance** _____

Policy/Group # _____ Policy/Group # _____ Policy/Group # _____

Member ID # _____ Member ID # _____ Member ID # _____

Owner of Policy _____ Owner of Policy _____ Owner of Policy _____

Relationship to Patient _____ Relationship to Patient _____ Relationship to Patient _____

Policy Holder D.O.B. _____ Policy Holder D.O.B. _____ Policy Holder D.O.B. _____

EMERGENCY CONTACT: _____ PHONE # _____

Please Turn Page Over

Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance, we anticipate helping you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. **You must realize however, that:**

1. Your insurance is a contract between you and your employer and the insurance company. **We are not a party to that contract.**
2. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Co-payments must be paid **at the time of service.**
4. If you have no insurance, payment for service is **due at the time of service** unless payment arrangements have been **approved in advance by our staff.** We accept cash, checks, MasterCard and Visa.

We must emphasize that as medical providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patient, all charges are your responsibility from the date the services are rendered and are to be paid in full within 90 days. We realize that temporary financial problems may arise and we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information, or any uncertainty regarding insurance coverage, **please do not hesitate to ask us.** We are here to help you.

Initial: _____

I hereby authorize Alabama Orthopaedic Center, P.C. to furnish information to the insurance carriers concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. **I understand that I am responsible for any amount not covered by insurance.** All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. Failure to make payment when requested is basis for legal action and the undersigned agrees to pay all costs of collection including a reasonable fee and hereby waive their right of exemption under the law of the State of Alabama and any other state.

Initial: _____

Medical Records

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to redisclosure by the recipient and may no longer be protected under federal law.

You may communicate with the following individuals regarding my condition or course of treatment:

Initial: _____

Responsibility For Non-Covered Services

The P.C. and/or physicians determine that there are certain routine services that are necessary for the maintenance of good health and standard medical care that are not covered by my (our) insurance contracts. I (We) hereby acknowledge, understand and agree to be fully responsible for any and all amounts charged by P.C. for such non-covered services. The P.C. and/or physicians will order only tests that are deemed medically necessary for the patient's treatment and care. Any questions regarding whether a certain service is covered by my (our) insurance contracts should be discussed with someone in the office of my insurance carriers. I (We) hereby acknowledge, understand and agree that I (we) have read the non-covered services policy of P.C. and agree to pay for any and all services not covered by my (our) insurance contract, which shall include, but not be limited to, those services set forth below:

Services That May Not Be Covered As Explained To The Patient:

ORTHOPAEDIC SUPPLIES AND/OR SPLINTS

Signature: _____ **Date:** _____

Responsible Party: _____ **Date:** _____

Alabama Orthopaedic Center, P.C.