COLONIAL ORTHOPAEDICS
COLONIALORTHO.COM

PATIENT INFORMATION

Today's Date_____ Chart#_____

Full Name_____ Sex: Male Female
LAST FIRST MIDDLE INITIAL

Street Address_____ P.O. Box_____

City_____ State_____ Zip Code_____

Home Phone_____ Work/Cell Phone_____

Birthdate_____ Age_____ Email_____

Referring Physician_____

Primary Care Physician_____

Marital Status: Married Single Divorced Widow Separated

Patient Employer_____

Emergency Contact Person_____
NAME TELEPHONE

Patient SSN_____ Spouse SSN_____

Parent's Name (if under age 18)_____
LAST FIRST MIDDLE INITIAL

Parent's SSN (if using parent's insurance)_____

Subscriber's Name_____Subscriber's Birthdate_____

Subscriber's Employer_____ Phone_____

Employer's Address_____

Reason for today's appointment_____

_____

Is this an injury? YES NO Onset of problem or Date of Injury_____

Pharmacy_____
NAME LOCATION PHONE

	Insurance Carrier Name	Subscriber/Policy Holder	Relationship to Patient	Subscriber/Policy Holder
Primary				
Secondary				

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Financial Agreement & Authorization

To prevent misunderstandings, please be advised that the patient is ultimately responsible for all bills. If you have insurance, under most circumstances, we will file the health insurance claim for you. However, the patient is responsible for all deductibles, co-payments and other allowable balances that his/her insurance does not pay. If you do not have health insurance and are not able to pay your bill in full, we do extend credit to our patients who need it. However, you must request to establish a payment plan before treatment or testing commences and sign a separate agreement.

If you are a member of a Health Maintenance Organization (HMO) or any other health plan that requires referrals, pre-authorization, and/or co-payments, it is our policy to obtain the referral(s) and the co-payment when you check in for your appointment. If you do not have the required referral(s) and/or pre-authorizations for your visit, x-ray(s), DXA scan, or any other supplies, we will delay or re-schedule your service until the required documentation is obtained. If you wish to proceed with your visit, x-ray(s), or DXA scan, without the authorizations required by your insurance carrier, you are financially responsible and must pay the full amount of the visit, x-ray(s), or DXA scan, prior to receiving service.

If you do not have your insurance card with you when you register as a new patient, you will be considered as a "private pay patient" and will be financially responsible for the visit, x-ray(s), or DXA scan, until such time the insurance card is presented to our office. You will be asked to sign a statement of responsibility. Your insurance is filed as a courtesy. If any additional forms are required, there will be a minimum charge of $20.00 per form. When a patient requests a copy of his/her x-rays, they will be provided in a reasonable amount of time for a charge of $15.00 per disc.

If this contract or any other debt owed to Colonial Orthopaedics is referred to a collection agency or attorney, I agree to pay all collection fees in the amount of thirty-three and one-third percent (33-1/3%) of the total indebtedness and court costs incurred by Colonial Orthopaedics. I understand and agree that should Colonial Orthopaedics be awarded judgment relating to this contract or any debt incurred thereof, I will pay a service charge of one and one-half percent (1-1/2%) per month; eighteen percent (18%) per annum, beginning on the date of judgment.

Signature_____ Date_____

Spouse's Signature_____ Date_____

I authorize the release of any medical or other information necessary to process medical claims for services furnished by Colonial Orthopaedics. I authorize the review of my medical records for my health plan for audit purposes. I also request payment of government benefits for such services either to myself or to the party who accepts assignment.

I authorize payment of medical benefits to Colonial Orthopaedics for any services furnished by that establishment through its physicians or suppliers for services as indicated/described on my insurance claim forms.

Patient Signature_____ Date_____

For Patients with Medicare

Beneficiary Name_____ Medicare Number_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Colonial Orthopaedics for any services furnished by that establishment. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents and information needed to determine these benefits or the benefits payable for related services.

Beneficiary Signature_____ Date_____