

**ATLANTIC ORTHOPAEDICS, P.A.
PATIENT INFORMATION**

Please complete each line and print clearly. Please complete front and back of form.

LAST NAME FIRST NAME MIDDLE INITIAL SOCIAL SECURITY #

LOCAL ADDRESS (STREET, CITY, STATE, & ZIP CODE) HOME TELEPHONE NUMBER

PERMANENT ADDRESS (STREET, CITY, STATE & ZIP CODE) CELL TELEPHONE NUMBER

E-Mail Address Emergency Contact Name and Telephone Number

DATE OF BIRTH _____ AGE _____ MALE/FEMALE (Circle One) Marital Status _____

Race _____ Referring Physician Name _____

Primary Care Physician _____ Pharmacy Name _____

Pharmacy Location _____ Pharmacy Telephone # _____

Is this a **WORK** or **AUTO** related injury? (Circle one) Date of Injury _____

Employer: _____

Claim Number _____ Contact Person _____ Telephone # _____

Insurance Company and Address to send claims: _____

Did you file an accident report? To Whom? _____

How did the accident occur? _____

RESPONSIBLE PARTY:

LAST NAME FIRST NAME MIDDLE INITIAL HOME TELEPHONE NUMBER

BIRTH DATE: _____ EMPLOYER: _____

Primary Insurance _____ Policy Number/ID# _____

Group Number _____ Group Name _____

Subscriber's Name _____ Subscriber's SS# _____

Subscriber's DOB: _____ Relationship to Patient _____

*NOTE: If the patient is a child and is covered under both parents' insurance, please indicate whose birthday (mother/father) is closest to January _____

Secondary Insurance _____	Policy Number/ID# _____
Group Number _____	Group Name _____
Subscriber's Name _____	Subscriber's SS# _____
Subscriber's DOB: _____	Relationship to Patient _____

PATIENT AGREEMENT FOR FINANCIAL RESPONSIBILITY

I, _____, understand that the physician's billing staff will file all claims for services rendered to my insurance carrier, if applicable. I also understand that if I am not insured, I must pay my balance for services rendered by my provider. I acknowledge that I am responsible for any balances that may be due to the physician because of: Co-insurance or co-pay amounts, yearly deductible amounts, non-covered services, out of Network charges, terminated coverage, exhausted auto benefits, denied Worker's Compensation claim, no insurance coverage, no referral obtained from Primary Physician, failure to respond to insurance carrier correspondence, and failure to respond to coordination of benefits inquiry.

I understand that I will receive a statement for any balance due, after my carrier has processed the claim. I understand and am agreeable that the balance of my statement will be paid in full to the physician within 30 days. If I am unable to pay the entire amount (applies to amounts of \$150.00 or more), I am responsible to immediately, upon receipt of statement, call the billing office @ 800-322-4606, to arrange a monthly payment plan, for no less than \$50.00 per month.

I understand that failure to pay my balance or arrange payments and follow that payment agreement may result in **Collection Agency** action and that I will be responsible for any charges incurred due to the collection process.

Signature of patient/guardian/responsible party

Date (mm/dd/yy)