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)