

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH _____ AGE: _____

LOCAL ADDRESS: _____

(city) (state) (zip) ()
(phone)

NORTHERN OR OTHER ADDRESS: _____

()

SOCIAL SECURITY #: _____ MARITAL STATUS: _____ SEX: MALE/FEMALE

EMERGENCY CONTACT PERSON _____ PHONE: () _____

YOUR CELL PHONE # _____ EMAIL ADDRESS _____

MEDICARE INFORMATION

Do you have traditional Medicare or a Medicare Replacement? Medicare / Replacement

Medicare ID number _____

Medicare Replacement Name _____ ID number _____

It is your responsibility to notify us of any changes in your Medicare Carrier

LIFETIME MEDICARE SIGNATURE

I certify that the information given for payment under Title XVII of the SSA is correct. I authorized the Institute for Orthopedic Surgery and Sports Medicine to use this signature as release to the social security administration or its intermediaries or carriers, or to billing agent of this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of an original. I may revoke this authorization by notifying the Institute for Orthopedic Surgery and Sports Medicine in writing.

Patient Signature

Date

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME _____ POLICY ID _____

WHO IS SUBSCRIBER _____ SS# _____ DOB _____

HOW DID YOU HEAR ABOUT OUR OFFICE FOR YOUR VISIT TODAY?

Doctor referred me for consultation: Name of Doctor _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION/RECORDS

1. I authorize Drs Fifer, Heligman, Gomez, Markovich, Hood, Follweiler, Kleiman and their employees or agents, to release medical and other information about me to my insurance company or its agents.
2. I authorize Drs Fifer, Heligman, Gomez, Markovich, Hood, Follweiler, and Kleiman to release any medical and other information to any health care provider or facility that the physicians deem appropriate.
3. I am aware that Drs Fifer, Heligman, Gomez, Markovich, Hood, Follweiler, and Kleiman routinely provide office notes on each visit to the office of my primary care physician. I authorize the release of these office notes and any other information that the physicians deem appropriate.
4. I am aware that I must complete a *REQUEST TO OBTAIN MEDICAL RECORDS* form in order for Drs Fifer, Heligman, Gomez, Markovich, Hood, Follweiler and Kleiman to release information or medical records to parties not listed.
5. I authorize Drs Fifer, Heligman, Gomez, Markovich, Hood, Follweiler, and Kleiman to release my records to me (the patient) for up to one year from this signed authorization. I understand that I may be charged for these records.

Patient Signature

Date

STATEMENT OF FINANCIAL RESPONSIBILITY

1. I assign payment of all insurance benefits under existing insurance policies to Drs Fifer, Heligman, Gomez, Markovich, Hood, Follweiler and Kleiman including funds payable to an attorney involved in the claim.
2. In the event that products and/or services are provided that are not covered by my plan(s) I will be responsible for payment for those products and/or services.
3. I understand that Drs Fifer, Heligman, Gomez, Markovich, Hood, Follweiler, and Kleiman submit claims to my insurance company on my behalf. I understand that I am responsible to insure that claims are paid by my insurance company and that I am financially responsible for products and/or services provided.
4. I authorized Drs Fifer, Heligman, Gomez, Markovich, Hood, Follweiler and Kleiman to apply any excess payments to any unpaid bills of myself or immediate family member.
5. I understand a portion of the payment is due at the time services are rendered.
6. I understand that Drs Fifer, Heligman, Gomez, Markovich, Hood, Follweiler, and Kleiman participate in many managed care plans and that companies, and plans within companies, differ in deliveries of care. It is my responsibility to remain current on insurance benefits. It is also my responsibility to insure that authorizations are obtained. We will provide care within your insurance plan guidelines whenever possible.
7. I understand that policies stated above and agree to accept responsibility as described.

Patient Signature

Date