

SOUTH BEND ORTHOPAEDICS SPORTS MEDICINE & REHABILITATION

PATIENT INFORMATION

ACCOUNT NUMBER _____

Last Name: _____ First Name: _____ M.I. _____ Marital Status: _____
 Street Address: _____ City: _____ State: _____ Zip: _____
 Home Phone #: (____) _____ SSN#: _____ - _____ - _____ Date of Birth: _____ - _____ - _____ Age: _____ Sex: _____
 Cell Phone # (____) _____ 9 Employed 9 Retired 9 Student (School) _____
 Patient's Employer: _____ Work Phone: (____) _____
 Employer's Address: _____ City: _____ State: _____ Zip: _____

X-rays taken?: 9 No 9 Yes Location: _____ When?: _____
 Condition/Injury being seen for: _____
 How and where did injury occur?: _____
 Injury: 9 No 9 Yes Date injury or symptoms occurred: _____ - _____ - _____ Work related: 9 No 9 Yes
 ALLERGIC to any medication?: 9 No 9 Yes List: _____
 Emergency Contact Person: _____ Relationship: _____ Emergency Contact Phone: (____) _____
 Referred by Dr.: _____ Address: _____ Phone: _____
First Name Last Name
 Family Dr.: _____ Address: _____ Phone: _____
First Name Last Name

Spouse or Policyholder: _____ Date of Birth: _____ - _____ - _____ Relationship to Patient: _____
 SSN#: _____ - _____ - _____ Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: (____) _____ Employer: _____ Work Phone: (____) _____
 Employer's Address: _____ City: _____ State: _____ Zip: _____

Parent or Policyholder: _____ Date of Birth: _____ - _____ - _____ Relationship to Patient: _____
 SSN#: _____ - _____ - _____ Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: (____) _____ Employer: _____ Work Phone: (____) _____
 Employer's Address: _____ City: _____ State: _____ Zip: _____

9 NO 9 YES **May we leave messages, which may include but are not limited to, information about prescriptions or test results on your answering machine?**
 9 NO 9 YES **May we leave messages, which may include but are not limited to, information about prescriptions or test results with members of your household?**

INSURANCE INFORMATION

| | <i>PRIMARY</i> | <i>SECONDARY</i> |
|------------------------------|----------------|------------------|
| INSURANCE CO. NAME | _____ | _____ |
| INSURANCE CO. ADDRESS | _____ | _____ |
| INSURANCE CO. CITY/STATE/ZIP | _____ | _____ |
| POLICY HOLDER'S NAME | _____ | _____ |
| GROUP NO. | _____ | _____ |
| POLICY NO. | _____ | _____ |
| EFFECTIVE DATE | _____ | _____ |

FINANCIAL RESPONSIBILITY I am responsible for the above patient, and or reimbursement and payment of claims from my insurance company. I understand that I am responsible for any amount not covered by insurance. If for any reason the account should become delinquent, I agree to pay for all collections and legal fees, and I hereby assign to the physician(s) all payment for medical services rendered to myself or my dependents.

SIGNATURE: _____ DATE: _____

PERSONAL DATA

INSURANCE

**CONSENT FOR TREATMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION
NOTICE OF SBO'S HIPPA POLICIES • SBO FINANCIAL POLICY • SBO'S POLICIES**

I hereby consent to and authorize South Bend Orthopaedics Sports Medicine and Rehabilitation (SBO), its associated physicians, medical residents, nurse practitioners, students and other healthcare providers, to provide and perform such medical and surgical care, tests, procedures, drugs and other services and supplies as are considered advisable by such health care providers for my health and well being. If I should not comply with the medical program of care provided or recommended by physician(s), or designated alternate(s), I understand that I then relieve my physician(s), designated alternate(s) and associated medical staff, and SBO of all responsibility resulting from my action.

I also authorize South Bend Orthopaedics Sports Medicine and Rehabilitation (SBO), all associated physicians and all associated agencies, to gather, maintain and release any and all of my information that may be required for the processing of any and all claims for third party payers (including but not exclusive of, private insurance, Medicaid, Medicare, Tricare, Disability, Workmen's Compensation, etc.)

I acknowledge that I have been given the ability to review SBO's Notice of Privacy Practices (effective 4-15-03). I acknowledge that I have been given the ability to review SBO's Policies (effective 11-1-04). I acknowledge that I have been given the ability to review SBO's Financial Policy. I authorize SBO to call my name out in the waiting room.

Patient Signature _____ Date _____ Time _____ AM/PM

Other Authorized Person _____ Relationship to Patient _____

Witness: _____

PATIENT MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished by or in South Bend Orthopaedics Sports Medicine & Rehabilitation, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

DATE _____ SIGNATURE _____

MEDIGAP AUTHORIZATION

I request that payment of authorized Medigap benefits be made either to me or on my behalf to South Bend Orthopaedics Sports Medicine & Rehabilitation for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to my Medigap insurer, _____, any information needed to determine these benefits or benefits for related services.

DATE _____ SIGNATURE _____

ADDITIONAL INFORMATION REQUEST FROM INSURANCE: Your insurance company may request additional information from you prior to processing the insurance claim for services provided to you. The request should be completed immediately and returned to the carrier. Failure to complete the questionnaire will result in denial of your claim. The service(s) provided will be your responsibility.

INITIALS: _____