

PATIENT INFORMATION SHEET

* denotes required fields

Appointment with DR.

Today's Date:

* E-Mail Address:

* **Patient Name (last, first, middle):**

* Home Phone:

*Address:

*City, State, Zip:

Birth Date (month, date, year):

Age:

Sex: Male Female

Marital Status:

Social Security:

Driver's License:

Patient's Employer:

Employer's Address:

City, State, Zip:

Employer's Phone:

Employer's Fax:

Occupation:

How Long Employed:

Name of Spouse or Parent if patient is minor:

Birth Date (month, date, year):

Social Security:

Driver's License:

Spouse or Parent's Employer:

Employer's Address:

City, State, Zip:

Employer's Phone:

Employer's Fax:

Occupation:

How Long Employed:

Referral Relationship:
Who sent you to see us:
(first & last name)

Your Family Doctor: (first & last name)

Name of Attorney, if any:

Phone Number of Attorney:

Fax Number of Attorney:

EMERGENCY INFORMATION:

Person to notify in case of emergency other than spouse:

Relationship:

Address:

City, State, Zip:

Home Phone:

Work Phone:

CO-ORDINATION OF BENEFITS: PRIMARY INSURANCE COVERAGE

Name of Primary Health Insurance:

Name of Subscriber:

Social Security # of Subscriber:

Employer:

Group #:

Effective Date of Insurance:

City, State, Zip:

Birth Date of Subscriber
(month, date, year):

Employer Phone:

Relationship to Subscriber:

Address of Primary Health
Insurance:

Phone Number of Primary
Insurance:

Co-Pay:

Are you covered under any other group medical plan?

Yes No If yes, please complete the section below.

Name of Secondary or Other
Health Ins:

Name of Subscriber:

Social Security # of Subscriber:

Birth Date of Subscriber
(month, date, year):

Group #:

Effective Date of Insurance:

Relationship to Subscriber:

Address of Secondary Health
Insurance:

Phone Number of Secondary
Insurance:

City, State, Zip:

Co-Pay:

AZALEA ORTHOPEDIC & SPORTS MEDICINE CLINIC, P.A.

CONSENT FOR TREATMENT

I hereby grant permission to the Azalea Orthopedic & Sports Medicine Clinic, P.A. physicians in charge of the case of the above-named patient to provide medical services to him/her as they deem necessary.

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered *a part of your treatment*. The following is a statement of OUR FINANCIAL POLICY which we require that you read, agree to, and sign prior to any treatment by our physicians.

Our office will file insurance claims for you, however, your share of the cost of our services is due at the time of service.

- We accept cash, checks, VISA, Discover, Mastercard, or American Express.
- For financial assistance please see our Financial Counselor prior to your visit with the Physician. A credit report will be obtained for extended credit.
- The adult bringing a minor for treatment is the responsible party for payment of our services.
- **INSURANCE: All HMO's and some PPO's require prior authorization (a referral #) from your primary care physician for each office visit. This is your responsibility. IF YOU DO NOT HAVE THIS REFERRAL NUMBER AT THE TIME OF YOUR APPOINTMENT, YOUR BENEFITS MAY BE PAID AT A REDUCED RATE OR NOT PAID AT ALL.**
- We accept **MEDICARE** assignments.
- We also accept **WORKERS' COMPENSATION** when properly verified in advance of the appointment. If your workers comp claim is later found to be non compensable and is finally adjudicated by TWCC, you will be responsible for your bill in full. If your employer is self -insured and fails to pay your worker's comp bill in full, you will be held responsible for the balance of the bill.
- **CO-PAYS: Your co-pays and deductibles are due at the time of service. In order to be eligible participants, we must sign contracts agreeing to collect co-payments at the time service is rendered, therefore, we must collect your co-pay at the close of your appointment. We are unable to bill for co-payments due to our contracts with your insurance company. Our office is simply following the orders of your managed care contract or insurance company. If we do not collect this co-payment, your insurance company may terminate our provider privileges.**
- **USUAL & CUSTOMARY CHARGES:** Our practice is committed to providing the best treatment possible for our patients. We charge what we believe to be the usual and customary fees for our area. You are responsible for paying the bill in full, regardless of your insurance company's interpretation of usual and customary rates.
- **MISSED APPOINTMENTS:** Unless canceled at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us to serve you better by keeping your scheduled appointments or canceling at least 24 hours in advance.
- **INVESTMENT INTERESTS:** Please be aware that the physician you are about to see may have an investment interest in other healthcare facilities within the community. He may or may not choose one of those facilities to perform diagnostic testing or surgery. Please feel free to ask the physician or a member of Azalea management if you have questions or concerns. You have the right to request your procedure be performed at another facility.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I HEREBY CERTIFY that the information entered above is true and accurate and that I have read, understand and agree to the above financial policy.

I understand that if more than one insurance company is involved (i.e. Motor Vehicle Accident or Liability Claim), I need to contact my Insurance Company regarding additional paperwork required of me before my claim will be processed.

I authorize payment of medical and surgical benefits to: AZALEA ORTHOPEDIC & SPORTS MEDICINE CLINIC, P. A. I understand that I am financially responsible for all charges regardless of insurance coverage.

I authorize AZALEA ORTHOPEDIC & SPORTS MEDICINE CLINIC, P. A., to furnish information to insurance carriers, treating physicians, employers, medical care facilities, etc., by any method, including fax, concerning this illness / accident.

This is to inform any Insurance Company involved to pay directly to AZALEA ORTHOPEDIC & SPORTS MEDICINE CLINIC, P. A. any monies due for care and treatment of any type of liability injury.

Patient Name:

Date: