



PATIENT INFORMATION

Date
Patient
Street Address
City
Home Phone
Cellular Phone
Social Security #
Single Married Widowed Separated Divorced
Race Ethnicity
Patient Employed by
Business Address
Pharmacy Name

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Whom may we thank for referring you?
Spouse (or Responsible Party) Name
Address (if different from patient's)
Home Phone
Social Security #
Business Name

INSURANCE

Who is responsible for this account?
Relationship to patient
#1 Primary insurance
Insured's Name
ID#
Group #
#2 Secondary insurance
Insured's Name
ID#
Group #

ASSIGNMENT AND AUTHORIZATION

I authorize and assign directly to Alliance Orthopaedics & Sports Medicine, PC all insurance benefits, if any, payable for any services rendered otherwise payable to me. I understand that my insurance coverage is a contract between myself and the insurance company. Alliance Orthopaedics & Sports Medicine is not a party to that contract. Therefore, I am financially responsible for any unpaid balance not covered by my insurance. Furthermore, I understand that this office will prepare any necessary claim forms to assist me in making collection from the insurance company. I authorize the release of all protected health information necessary to insurers (including Medicare, if appropriate) to secure payment of benefits.

I also understand that:

- All copays, deductibles, and coinsurances not covered by my insurance carrier are my responsibility and will be due at the time of service.
All accounts not covered by insurance are due and payable in full at the time of service. Forms of payment accepted are cash, checks, and all major credit cards.
It is my responsibility to make sure that the insurance information provided is accurate and up to date. If it is not, I am responsible for charges that are denied because of not filing to the right place in a timely fashion.
It is my responsibility to obtain any referrals required by my insurance company from my primary care physician. It is my responsibility to make sure that my referral is accurate, and denial of payment because of my failure to do this will result in my being personally responsible for the charges incurred.
I will be assessed a collection fee in the event that an outside collection agency or an attorney is used to settle my unpaid debt.

LATE CANCELLATIONS AND NO-SHOWS: We understand that sometimes the unexpected can happen and you may be unable to keep an appointment. We would appreciate 24 hours notice prior to a scheduled appointment if you need to cancel or reschedule. Your consideration will permit us to schedule other patients who may be waiting to be scheduled.

Patient's (Guardian's) Signature
Date