WEST END ORTHOPAEDIC CLINIC

Patient Check-In Form

Name of Physician to see today: ______________________________
Name of Physician who sent you here today: ______________________________
Name of your Family Practice doctor: ______________________________
Body Area being seen for today: ______________________________
(i.e. right leg, left hip, etc.)

Problem? Y N Date Problem Began: ____________
Injury? Y N Date of Injury: ____________
Work Injury? Y N Date of Injury: ____________
Auto Accident? Y N Date of Accident: ____________ State of Accident: _______

Patient Name ____________ ____ ____________
First *M* *Last*

Address ______________________________
____

Phone Number(s) (If child, phone numbers for parent)
Home: (___)____________ Office: (___)____________ Cell: (___)____________
Email: ______________________________ May we contact you by email? Y N

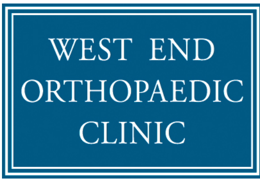
Date of Birth: ___/____/______ SSN: ____________
Marital Status: _____ Sex: ____ Occupation: ____________

Employer: ______________________________
Employer Address: ______________________________
____
City *State* *Zip*
Employer Phone: (____)______________

Emergency Contact(s): ______________________________
____
Name *Phone #*

Primary Insurance Name: ______________________________
Policyholder Name: ______________________________
Date of Birth of Policyholder: ____/___/_____
Relationship of Policyholder to Patient: ____________
Policyholder SSN (One Net only): ____________
Policyholder Employer/Address (One Net only): ____________
____

Secondary Insurance Name: ______________________________
Policyholder Name: ______________________________
Date of Birth of Policyholder: ____/___/_____
Relationship of Policyholder to Patient: ____________



Assignment of Benefits

Release of Information

I authorize West End Orthopaedic Clinic to release information related to my care to the hospital, physician, insurance company, or agent of West End Orthopaedic Clinic who requests such information if required or permitted by law. In addition, I authorize West End Orthopaedic Clinic to access information from the hospital's computer system and allow the hospital or physician office to fax records pertinent to my care.

Patient Financial Responsibility

I acknowledge that I am personally responsible to pay for any unpaid balance specified by my insurance, including co-payments, co-insurances, or deductibles; or, if I have no insurance, the Clinic's fee. If my account is sent to an outside collections agency, West End Orthopaedic Clinic will charge 1-1/2% per month (18% per year) on fees outstanding greater than 90 days, in addition to court fees and attorney fees in the amount of 25% of the outstanding balance. I understand that West End Orthopaedic Clinic reserves the right to charge a $25 fee for checks returned for non-sufficient funds.

Insurance Requirements

It is the patient's responsibility to ensure that insurance requirements for care are met. This includes any prior approvals, authorizations, and/or referrals required prior to services rendered. I authorize my insurance to make payments directly to West End Orthopaedic Clinic for services provided.

Medicare Patients

West End Orthopaedic Clinic is a participating provider; therefore, I request that payment for authorized Medicare benefits be made directly to West End Orthopaedic Clinic. If needed for benefits determination, I authorize the release of medical information to the Center for Medicare/ Medicaid Services and its agents.

Auto/Liability Injury

I authorize my attorney and/or any insurance company providing benefits to me to pay the balance due in full on any account for me directly to West End Orthopaedic Clinic as soon as they receive compensation from any source including, but not limited to, any insurance policies providing coverage for liability, uninsured motorist, underinsured motorist, medical payments and/or health insurance, settlement and/or verdict of the Court. WE WILL NOT HOLD YOUR ACCOUNT OPEN DURING THE PERIOD OF LITIGATION.

Patient Signature: ______________________________________ **Date:** _____________

Responsible Party Signature: _____________________________ **Date:** _____________