

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 the patient is a child, provide the parent's phone numbers)
Home Office Cell

Date of Birth SSN

Marital Status Sex Occupation

Employer

Employer Address

City State Zip

Employer Phone

Emergency Contact(s)

Name Phone #

\*\*\*\*\*

Primary Insurance Name

Insured Name (as per card)

Date of Birth of Insured (person whose name is on the card)

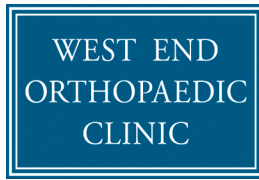
Relationship of Insured to patient

Secondary Insurance Name

Insured Name (as per card)

Date of Birth of Insured (person whose name is on the card)

Relationship of Insured 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 insufficient 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 service(s) rendered. I authorize my insurance to make payment for services rendered directly to West End Orthopaedic Clinic.

### **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 Insurance**

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 payment and/or health insurance, settlement and/or verdict of the Court. WE WILL NOT HOLD YOUR ACCOUNT OPEN DUREING THE PERIOD OF LITIGATION.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_