

## 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): \_\_\_\_\_

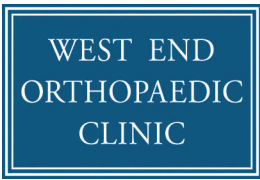
Policyholder Employer/Address (One Net only): \_\_\_\_\_

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:** \_\_\_\_\_