

SC Sports Medicine & Orthopaedic Center
PATIENT INFORMATION FORM

Patient First Name: _____ MI: _____ Last Name: _____

Age: _____ Date of Birth: _____ Sex: M F SS#: _____ - _____ - _____ Marital Status: _____

Address: _____ Apt #: _____ City: _____ ST: _____ Zip: _____

Home Phone:() _____ Work Phone:() _____ EXT.: _____ Occupation: _____

Employer: _____

Employer Address: _____

Name of Spouse (if applicable): _____ SS#: _____ - _____ - _____

Employer: _____ Phone #:() _____

Family/Primary Care Doctor: _____ Referring Doctor: _____

IF THE PATIENT IS A CHILD OR FULL TIME STUDENT, PLEASE COMPLETE THIS SECTION

Name of Responsible Party for This Patient's Bill: _____

(Note: Must be self, parent, or legal guardian)

Address: _____ Apt #: _____ City: _____ ST: _____ Zip: _____

Name of School: _____ Address: _____

Mother's Name: _____ SS#: _____ - _____ - _____ Date of Birth: _____

Employer: _____ Phone #:() _____

Father's Name: _____ SS#: _____ - _____ - _____ Date of Birth: _____

Employer: _____ Phone #:() _____

PRIMARY INSURANCE

Name of Insurance Co.: _____ I.D.#: _____ Group # _____

Address of Insurance Co.: _____

Name of Insured (as it appears on card): _____ Insured's DOB: _____

SECONDARY INSURANCE

Name of Insurance Co.: _____ I.D.#: _____ Group # _____

Address of Insurance Co.: _____

Name of Insured (as it appears on card): _____ Insured's DOB: _____

Is This Visit the Result of an Accident ? Yes/No (Circle One) Work School Auto Other Date of Accident: _____

How Did You Hear About Us? _____

IN CASE OF AN EMERGENCY, NOTIFY: _____

Name	Relationship	Phone #
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REQUIRED SIGNATURES

FOR INTERNAL USE ONLY: Dr. SK - BW - JD - JDEV - ES - MK Chart review and update _____

PLEASE READ AND SIGN SECTIONS I, II, and SECTION III OR IV PER INSURANCE TYPE.

I. Financial Policy & Payment Responsibility: Payment for medical services is the responsibility of the patient or in the case of a minor the signed responsible party. Our office will file for insurance benefits for plans in which we **do participate.** (See List of Participating Plans). Payment for deductible, co-insurance and co-payment amounts will be collected from the patient at time of service. If your insurance plan does not pay your medical services within 30 days, all charges may be due and payable in full from the patient. Your help in seeing that your insurance pays for your medical services within the specified time period is appreciated.

For insurance plans in which we **do not participate,** our office will file a claim to your insurance plan as a courtesy. Full payment of charges will be collected from the patient at time of service, unless special arrangements have been approved in advance.

An interest charge of 1% per month will be assessed to account balances 30 days or older. We reserve the right to obtain a credit report and/ or report to credit bureaus the status of your account due to delinquent account balances. A fee of \$25.00 will be charged to your account for Returned Checks.

Method of Payment: _____Cash _____Check _____VISA _____MC _____Discover

Patient or Responsible Party Signature: _____ **Date:** _____

II. Medical Release Authorization: I authorize South Carolina Sports Medicine and Orthopaedic Center to release any medical information obtained in the course of my diagnosis and treatment to any referring physicians and other health care providers, hospitals and medical facilities, and to my insurance carriers. I understand that this information may include reference to psychiatric care, sexual assault, alcohol and/or drug abuse and results of test for all infectious diseases including AIDS/HIV.

Patient or Responsible Party Signature: _____ **Date:** _____

III. Assignment of Insurance Benefits: I hereby assign and authorize payment to South Carolina Sports Medicine and Orthopaedic Center of all medical and surgical benefits to which I am entitled, including health insurance benefits, major medical benefits, and third party liability coverage including personal injury protection (PIP) benefits and other medical payment coverage or other policy coverage for which I am entitled. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I hereby authorize South Carolina Sports Medicine and Orthopaedic Center to release all information necessary to secure payment of insurance benefits. **I understand that I am financially responsible for all charges whether or not paid by said insurance(s).**

Patient or Policy Holder Signature: _____ **Date:** _____

IV. Medicare Insurance (SIGNATURE ON FILE): I request payment of authorized Medicare benefits be made payable to South Carolina Sports Medicine and Orthopedic Center for any services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and **non-covered** services. I authorize Health Care Financing Administration to release information to process claims for Medigap or secondary insurance.

Patient Signature: _____ **Date:** _____