MIDSOUTH ORTHOPAEDIC REHABILITATION, LLC
Child Form

DATE:_____ **CHART # _____**

Patient Name_____ Date of Birth:_____ Age:_____

Address of Patient:_____City_____State_____Zip_____ Male☐Female☐

Social Security #:_____ Home Phone:(____)_____ Cell Phone:(____)_____

School Attending:_____

Referred by: _____ Phone: _____

Family Physician: _____ Phone: _____

REASON for this visit: _____ Date of first symptom(s): _____

Were you injured? Yes☐No☐ If so, how? _____

Emergency Contact:_____ Relationship:_____ Phone:(____)_____
(not living at same address as patient)

What was the greatest factor in you choosing our clinic: ☐Physician referred**,** ☐ Family/friend referred, ☐ Insurance provider list ☐ Yellow pages ☐Other, _____

Mark any of our advertisements you have seen: ☐Website, ☐Memphis Health & Fitness Magazine**,** ☐Germantown Magazine, ☐ Yellow pages, ☐ Other**,** _____

LEGAL GUARDIAN INFORMATION

(If under 18 years of age)

Motherôs Name:_____DOB_____Are you a legal guardian?☐Yes☐No
Employerôs Name_____Occupation:_____
Employerôs Address_____ City_____State_____Zip_____
Work#_____Home#_____Cell#_____Soc Sec#_____

Fatherôs Name:_____DOB_____Are you a legal guardian? ☐Yes☐No
Employerôs Name_____Occupation:_____
Employerôs Address_____ City_____State_____Zip_____
Work#_____Home#_____Cell#_____Soc Sec#_____

	PRIMARY:	**SECONDARY:**
Insurance Company:	(**1**)_____	(**2**)_____
Subscriberôs:	Date of Birth:_____ Male/Female	Date of Birth:_____ ☐Male☐Female
Subscriber's	Soc Sec#:_____	Soc Sec#_____
Name of Subscriber:	_____	_____

FINANCIAL RESPONSIBILITY

WE WILL FILE YOUR PRIVATE HEALTH INSURANCE AND YOU WILL RECEIVE EXPLANATION OF BENEFITS. AT THE TIME OF EACH VISIT, YOU ARE RESPONSIBLE FOR PAYING CO-PAYS, DEDUCTIBLES, AND BALANCE DUE AFTER FILING INSURANCE. YOU ARE RESPONSIBLE FOR PROMPTLY RESPONDING TO ALL INSURANCE INQUIRES.

I ACCEPT PERSONAL RESPONSIBILITY FOR PAYMENT OF CHARGES FOR SERVICES RENDERED TO ME. I AUTHORIZE BILLING AND PAYMENTS OF MEDICAL INSURANCE BENEFITS TO MIDSOUTH ORTHOPAEDIC REHABILITATION. I UNDERSTAND THAT A PROFIT IS COLLECTED FROM ANY DME OR SUPPLY I PURHCASE FROM THIS OFFICE. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR A $50 CHARGE FOR FAILURE TO GIVE 24 HOURS NOTICE OF CANCELLATION/RESCHEDULING. IF MY ACCOUNT HAS TO BE ASSIGNED TO AN ATTORNEY FOR COLLECTION OF SUIT, I WILL BE RESPONSIBLE FOR LEGAL FEES AND COLLECTION COST, WHICH MAY BE AS MUCH AS 40% OF THE ORIGINAL AMOUNT. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS.

I HAVE RECEIVED A COPY OF THE HIPAA/PRIVACY ACT.
DATE: _____ SIGNATURE OF PATIENT/INSURED:_____

7730 Wolf River Blvd. Suite 109 ŁGermantown TN 38138 ŁPH 901-522-MOR1 ŁFax 901-522-6715