

MIDSOUTH ORTHOPAEDIC REHABILITATION, LLC

DATE: _____

CHART # _____

Mr., Mrs., Miss, Ms. _____ Date of Birth: _____ Age: _____

Address: _____ Single Employed Male
Married Student Female
City: _____ State: _____ Zip: _____ Other

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

Employer or School Attending: _____ Work Phone:(____) _____

Referred by: _____ Phone: _____

Family Physician: _____ Phone: _____

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

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

WORK RELATED: Yes No Auto Accident: Yes No Law Suit Pending: Yes No

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, _____

EMERGENCY INFORMATION :

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

Insurance Company: **PRIMARY:** (1) _____ **SECONDARY:** (2) _____

Subscriber's: 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 PURCHASE 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: _____