

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)

Mother's Name: _____ DOB _____ Are you a legal guardian? Yes No

Employer's Name _____ Occupation: _____

Employer's Address _____ City _____ State _____ Zip _____

Work# _____ Home# _____ Cell# _____ Soc Sec# _____

Father's Name: _____ DOB _____ Are you a legal guardian? Yes No

Employer's Name _____ Occupation: _____

Employer's Address _____ City _____ State _____ Zip _____

Work# _____ Home# _____ Cell# _____ Soc Sec# _____

PRIMARY:

SECONDARY:

Insurance Company: (1) _____ (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: _____