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 ☐

Email:____ Home Phone:(____)________________

Social Security #:___________________________ Cell Phone:(_____)_________________ Work Phone:(____)___________________

Employer or School Attending:____ Job Title:_______________________________

Time related to Activities required with work: Sit____%; Stand____%; Walk____%; Lift < 10 lbs ____%; Lift > 10lbs___% Other___%(specify)

Referred by: ____ Phone: _______________________________

Family Physician: ____ Phone: _______________________________

Part of Body here for: ____ 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 ; **Permanently Disabled** ☐ Yes ☐ No

What was the greatest factor in you choosing our clinic: ☐ Physician referred, ☐ Family/friend referred, ☐ Insurance provider list ☐ Website/Internet ☐ Other, ________________________________

Mark any of our advertisements you have seen: ☐ Website, ☐ Business Networking International (BNI), ☐ Community Event (specify), ☐ Yellow pages, ☐ Other, ____

EMERGENCY INFORMATION :

Emergency Contact:________________________________ Relationship:_________________ Phone:(____)___________________

(not living at same address as patient)

	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 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:**_______________________________________