

# SPORTS MEDICINE CENTER / SPORTS MEDICINE DAY SURGERY

NAME: (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (MI) \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: M \_\_\_ F \_\_\_ SS# \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

MARITAL STATUS:  S  M  W  D E-MAIL ADDRESS: \_\_\_\_\_

HOME #: \_\_\_\_\_ CELL#: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WK#: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_ NUMBER: \_\_\_\_\_

RESPONSIBLE PARTY NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

## PRIMARY INSURANCE [ SEE ATTACHED COPY OF CARD(S) ]

COMPANY: \_\_\_\_\_ PHONE #: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_

SS#: \_\_\_\_\_

## SECONDARY INSURANCE

COMPANY: \_\_\_\_\_ PHONE \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_ SS#: \_\_\_\_\_

## WORKERS COMPENSATION CLAIM / 3<sup>RD</sup> PARTY CLAIM / AUTO ACCIDENT CLAIM

COMPANY: \_\_\_\_\_ PHONE#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_ CLAIMS MNGR: \_\_\_\_\_

CLAIM #: \_\_\_\_\_ CLAIM OPEN: Y / N CLAIM

CLOSED: Y / N \*IF YES-DATE: \_\_\_\_\_

## INJURY INFORMATION

WORK RELATED INJURY: Y / N

DATE OF INJURY: \_\_\_\_\_

AUTO ACCIDENT: Y / N

INJURED BODY PART: \_\_\_\_\_

3<sup>RD</sup> PARTY ACCIDENT: Y / N

CAUSE: \_\_\_\_\_

OTHER INJURY: Y / N

## **PATIENT / GUARANTOR NOTIFICATION \*\*\*\* PLEASE READ, SIGN AND DATE BELOW**

I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL. I AUTHORIZE SPORTS MEDICINE CENTER / SPORTS MEDICINE DAY SURGERY TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES. I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO COLLECT ANY PAYMENTS TO ALL MY INSURANCE COMPANIES. I FURTHER AUTHORIZE RELEASE OF MEDICAL INFORMATION TO ANY AND ALL PHYSICIANS INVOLVED IN MY CARE. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN THE PLACE OF ITS ORIGINAL. I AUTHORIZE THE USE OF SIGNATURE ON FILE TO BE USED ON ALL MY INSURANCE SUBMISSIONS. I UNDERSTAND THAT I AM RESPONSIBLE FOR NOTIFYING THE OFFICE OF ANY PRECERTIFICATION, REFERRALS OR CHANGES NEEDED FOR MY INSURANCE.

**ATTENTION:** Listed below are the finance charges that will become YOUR RESPONSIBILITY AND NOT BILLED TO INSURANCE:

\* \$25.00 for appointments not cancelled within 24 hours of your appointment time. Your insurance will not be billed for this fee, this fee is the responsibility of the patient.

\* \$250.00 for surgery appointments not cancelled within 24 hours of your appointment time. Your insurance will not be billed for this fee, this fee is the responsibility of the patient.

\* 1% rebilling fees every month for balances over 60 days.

\* \$25.00 for non-sufficient funds

SIGNATURE OF PATIENT / GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_