Ortho Sport therapy & rehab

For Office Use Only
Ortho Sport Acct # _____

Initials _____

PATIENT REGISTRATION FORM

Date _____ Age _____ Marital Status _____

Last Name _____ First Name _____ MI __

Home Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Social Security # _____

Home Phone ( ) _____ Work Phone ( ) _____ x ____

Cell Phone ( ) _____ Employer's Name _____

Spouse/Guardian's Name _____ & Date of Birth _____

Spouse/Guardian's Employer _____ Work # _____

Spouse's Social Security # _____Alt Phone # _____

Emergency Contact Name _____ Relationship _____

Address _____ Phone # _____

Who requested that we see you in consultation? _____

Family Physician _____

Insurance Information

Primary Insurance Company _____

Name of Policy Holder _____Policy Holder DOB_____

Policy # _____ Group # _____

Secondary Insurance Company _____

Name of Policy Owner _____

Policy # _____ Group # _____

Do you have a Co-Pay with your insurance plan for office visits? _____

If yes, what is the amount? _____ Co-Pay's are due at the time of service.

Work Comp/IME Information (if applicable):

Name of Work Comp Insurance Company _____

Address _____

City _____ State _____ Zip _____

Claim # _____ Claims Adjuster _____

Phone # ( ) _____ ext _____ Fax # ( ) _____

Case Manager _____ Phone # ( ) _____

Date of Injury _____

Auto Insurance Information (if applicable):

Name of Patient's Auto Insurance Company _____

Address _____ City _____ State _____ Zip _____

Claim # _____Date of Accident _____

Name of person handling claim _____

Assignment of Benefits

I hereby authorize Omaha Orthopedic Clinic to furnish third party payors with any information concerning the medical care, treatment and billing.

I hereby assign Omaha Orthopedic Clinic all payments for medical services rendered to me or my dependants, and I authorize direct payment of such benefits to Omaha Orthopedic Clinic and any third party payor. I understand that I am responsible for all medical fees and costs regardless of the insurance coverage and that Medicare and insurance plans require that all co-pays and deductibles be collected. To the extent there is multiple coverage by third party payors such benefits shall be coordinated and the collection of any deductibles, co-insurance or co-payments up to the full amount of the account balance shall be permitted, and I shall remain responsible for the said amount. I agree to pay a late charge at the rate of 1-1/3 percent per month on any amounts due from and after the 31st day following the invoice date until paid in full if there is no applicable insurance coverage. If a claim is pending with a third party payor, no interest shall accrue until such time as the third party payor denies all or part of the claim, in which case I agree to pay a late charge at the rate of 1-1/3 percent per month on any unpaid amounts from and after the 31st day following the date Omaha Orthopedic Clinic or I receive notice of the same, whichever is earlier. I also agree that if any dispute arises between Omaha Orthopedic Clinic and me, the laws of the State of Nebraska shall govern, and all disputes between Omaha Orthopedic Clinic and me must only be litigated in the appropriate court in Douglas County, Nebraska, and I consent to personal jurisdiction and venue being proper in the appropriate court located in Douglas County, Nebraska.

Date: _____ Signature: _____