Bone & Joint Specialists

PATIENT NAME: _____ Cellular#_____
First Middle Last

Address: _____ Apt./Sp.#: _____
City: _____ State: _____ Zip: _____
Home Phone #: ( ) _____ - _____ Work Phone #: ( ) _____ - _____
Social Security #: _____ - _____ - _____ Date of Birth: _____ Age: _____ Male Female

Employer: _____ How Long? _____
Employer Address: _____ Occupation: _____

Referring Physician: _____ Address: _____

******Complete this section only if someone other than the patient is financially responsible*********

*Responsible Party: _____ Relationship to Patient_____
*Home Address: _____
*Telephone #: ( ) _____ Birthdate: _____ Age: _____
*Employer: _____ Employer Address: _____
*Social Security#: _____ Work Phone: ( ) _____

EMERGENCY CONTACT: (NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU).

Contact Name: _____ Relationship to Patient: _____
Home Phone: ( ) _____ - _____ Cellular #: ( ) _____ - _____

WHAT BODY PART ARE WE SEEING YOU FOR?: _____
DATE OF INJURY/ONSET: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Policy ID#: _____ Group#_____
Address: _____ City/State/Zip _____
Date of Birth: _____/_____/_____ Insured Name: _____

Secondary Insurance: _____ Policy ID#: _____ Group#_____
Address: _____ City/State/Zip _____
Date of Birth: _____/_____/_____ Insured Name: _____

Worker's Comp Insurance Name: _____
If Worker's Comp, claim#: _____ Date of Injury: _____
Worker's Comp Adjusters Name: _____ Phone#: _____
Fax#: _____ Nurse Case Manager Name: _____

I hereby assign all medical benefits to which I am entitled to Bone & Joint Specialists. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorized said assignee to release any information needed to determine these benefits or the benefits for related services.

_____ _____
Responsible Party Signature Date

Bone & Joint Specialists

Body part being treated for? _____

Any previous problems with this same body part in the past? Yes No
If yes, Please list: _____

_____

Have you been seen by any other doctor for your present problem? Yes No
If yes, which doctor and when? _____

Have X-rays or any diagnostic studies been done? (ex: MRI's;CT;Bone Scan; and EMG studies)
If yes, Where, When and What body part? _____

_____

List all prescribed medications you are currently taking:

_____

_____

Allergies to Medication: Yes No
If yes, please list which medication: _____

List All Previous Surgeries: _____

_____

Any Medical Health Problems-Please list: _____

_____

Do you smoke? Yes No How many packs a day? _____

Do you drink alcohol? Yes No How often? _____

PATIENT NAME: _____ DATE: _____

BILLING INFORMATION

INJURY INFORMATION

If not an injury, what problems are you having? _____

If being seen for an injury, How and where did the injury occur? _____

_____

********ONLY COMPLETE THIS SECTION IF MOTOR VEHICLE ACCIDENT **********

What is the name of the insurance company? _____

Insurance company address: _____

Claims adjusters name: _____ Phone#: ( ) _____

DO YOU HAVE AN ATTORNEY FOR YOUR INJURY? YES NO

Attorney's Name: _____ Phone#: ( ) _____ - _____

Attorney's Address: _____

IF THERE IS A LIEN SIGNED WITH YOUR ATTORNEY, THERE WILL BE A $250 DEPOSIT REQUIRED

********ONLY COMPLETE THIS SECTION IF INJURED ON THE JOB**********

Did the injury occur at work? YES NO

If yes, please explain the injury details: _____

_____

Date the injury occurred: _____

Did you report the injury to a supervisor? YES NO Supervisor's Name: _____

Have you had any previous Worker's Compensation injuries in the past? YES NO

If yes, please explain: _____

PATIENTS NAME: _____ DATE: _____

BONE & JOINT SPECIALISTS

DISCLOSURE:

Bone and Joint Specialists is a for-profit corporation solely owned by the physicians providing medical services to the community.

FINANCIAL POLICY:

PAYMENT FOR MEDICAL SERVICES RENDERED IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Our office does verify eligibility and benefits with your health insurance company. If we are unable to accomplish this, you will be asked to pay for services rendered until we can confirm your eligibility status. We will do all we can to assist you with your health insurance claims however, insurance is a contract between the insurance company and the insured. Final responsibility for payment of your account rests with you. Our office will bill a secondary insurance only once as a courtesy to the patient. If the insurance does not pay, then the balance becomes the responsibility of the insured.

If you are scheduled for surgery, we require any deductible's as well as coinsurance amounts paid prior to your date of surgery. In addition to the surgeon's fee, there is a need for an assistant at the time of your surgery. The assistant's fee is in addition to the surgeon's fee.

Any prior authorizations obtained by this office on behalf of you, the patient, are not a guarantee of payment, but are based on medical necessity. Claims are subject to your policy provisions and final payment is determined only when your insurance company has received the claim. If you have any questions regarding our medical fees or questions regarding your insurance benefits, please speak with a billing specialist.

A returned check charge of $35.00 will be charged to the account for each returned check.

DELINQUENT AND COLLECTION ACCOUNTS:

- An account becomes delinquent when the minimal monthly payment has not been received within 30 days of the statement date.
- An account that has become delinquent for 60 days, may become a collections account and may be charged a collections handling fee, court cost's and attorney's fee's.
- Exemptions from the above are allowed charges under Medicare and Title XIX (Nevada Medicaid) contracts.
- There may be exceptions to all or any part of the account.
- Balances not paid by your insurance plan within 30 days, will automatically become the responsibility of the responsible party.

I understand that Bone & Joint Specialists may not be a provider on my health plan, and I will be fully responsible for any outstanding charges that my insurance plan does not cover. A photocopy of this assignment is considered as valid as the original.

In the event that my account becomes a delinquent account or a collection account, I agree to pay Bone & Joint Specialists all incurred Finance Charges, Delinquent Account Handling Fee's, Collection Account Handling Fee's and incurred Collection cost's as set forth above in section 3 of the financial policy.

If it is necessary to forward your account to our Collection Agency, a Collection Fee markup of 35 to 50% will be added to the amount owing. Interest will accrue daily at the rate of 1.5% per month or 18% per year.

The mark-up reflects Bone & Joint Specialists receiving only it's billed charges. The additional money will go to the collection agency.

Signature of Responsible Party: _____ **Date:** _____