

Patient Registration Form

Patient Name: _____ Date of Birth: ____/____/____ Age: _____

Sex: M / F SS #: ____-____-____ Circle one: Married/ Single/ Divorced/ Widow

Address: _____
(Street) (City, State, Zip)

Home #: () ____-____ Work #: () ____-____ Cell #: () ____-____

Is Your Visit Due to a Job Related Injury or Automobile Accident? Yes No

Employer Name: _____ Employer Phone: () ____-____

Employer Address: _____
(Street) (City, State, Zip)

How did you hear of us? _____

Person responsible for bill (Complete only if not the patient)

Guarantor Name: _____ SS #: ____-____-____

Relationship to Patient: _____

Date of Birth: ____/____/____ SS #: ____-____-____ Phone #: () ____-____

Address: _____
(Street) (City, State, Zip)

Employer Name: _____ Employer Phone #: () - ____-____

Employer Address: _____
(Street) (City, State, Zip)

Who To Contact For An Emergency:

Name: _____ Relationship: _____

Home # () ____-____ Cell #: () ____-____ Work #: () ____-____

Primary Insurance Information: *Please Present Your Insurance Card To Be Copied By Receptionist*

Plan Name: _____ I.D. Number: _____

Policy Holder: _____ Group Number: _____

Date of Birth: ____/____/____ Sex: M / F Effective Date: ____/____/____

Secondary Insurance Information: *Please Present Your Insurance Card To Be Copied By Receptionist*

Plan Name: _____ I.D. Number: _____

Policy Holder: _____ Group Number: _____

Date of Birth: ____/____/____ Sex: M / F Effective Date: ____/____/____

ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. FEES ARE PAYABLE AT THE TIME OF EXAMINATION. SHOULD PATIENT FAIL TO PAY AS AGREED ABOVE, THEN THE PATIENT SHALL BE LIABLE FOR ALL COSTS AND EXPENSES OF ATLAS ORTHOPAEDICS INCURRED IN COLLECTION OF PATIENT'S ACCOUNT, INCLUDING REASONABLE ATTORNEY'S FEES AND COURT COSTS. I UNDERSTAND THAT IN THE EVENT I FAIL TO MAKE PAYMENT ON MY ACCOUNT IT WILL BE TURNED OVER TO COLLECTIONS AND APLICABLE COLLECTION FEES WILL BE APPLIED.

I request that payment of authorized insurance carrier benefits be made on my behalf to Duncan Wells, M.D. for any services furnished me by that practice. I authorize any holder of medical information about me to release to the health care financing administration and it's agents any information needed to determine these benefits. I understand that my signature requests that payment be made and authorizes release of medical information to pay any claims. In Medicare/Medicaid, or other insurance carrier assigned cases , the practice agrees to accept the charges of said insurance carrier as the full charge and the patient is responsible only for the deductible , co-insurance and non-covered services. A copy of this authorization shall be valid as the original.

HIPPA (Health Insurance Portability and Accountability Act of 1996): If you would like to receive a copy of HIPPA please see receptionist. This is to acknowledge that I have read and received a copy of the privacy practices.

Signature: _____

Date: _____

Patient Name _____

It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you.

It is our office policy to bill your insurance carrier(s) as a courtesy to you, although you are responsible for the entire balance now. Once the carrier(s) is (are) billed, we will set aside that portion of the balance estimated to be paid by your insurance carrier for 30 days. We require that your estimated share be paid now. If your insurance carrier does not remit payment within 30 days, the balance will be due in full from you. Since we are not a party to the agreement with your insurance carrier it is not our policy to contact carriers to establish why they haven't paid or why they paid less than originally indicated. If any payment is subsequently made by your insurance carrier in excess of the balance we estimated, we will promptly refund the credit amount to you.

_____ **1. Patient with Insurance**

You are responsible for deductibles, co-pays, non-covered services, coinsurance and items considered "not medically necessary" by your insurance company. Please pay co-payments and coinsurance amounts as services are rendered. The remaining balance should be taken care of within one (1) month of notice from insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the front desk staff to make other arrangements.

_____ **2. Worker's Compensation Patient**

As a Worker's Compensation patient you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment. Patient is ultimately responsible for balance.

_____ **3. Personal Injury (Accident)**

If you are a personal injury patient, our office will bill the appropriate insurance companies. If we are unable to obtain payment, charges for the services rendered will be your responsibility. Please give all information needed for billing. If an attorney is involved and asks you not to submit insurance claims, a doctors lien must be signed by you and your attorney.

_____ **4. Medicare**

Our office will submit your Medicare charges to WPS Medicare and your secondary insurance. You are responsible for deductibles, co-pays, and any non-covered services.

ASSIGNMENT

_____ I request that payment of authorized Medicare benefits be made either to me or on my behalf to Duncan Wells M.D. for any service furnished me by that provider. Medicare Number _____

_____ The signature below authorizes payment of mandated Medigap benefits to Duncan Wells M.D.

Medigap _____ Policy Number _____ Group Number _____

RELEASE OF INFORMATION

_____ I authorize Duncan Wells M.D. to release to my insurance carrier(s) and / or CMS (formerly HCFA) and its agents and / or my Medigap insurer any information needed to determine benefits or benefits payable for related services.

I have read and agree to the Financial Policy, Assignment, and Release of Information paragraphs stated above that apply to me.

X _____
Patient or responsible party Signature

Date _____

X _____
Person signing on behalf of patient (Print Name)

Reason Patient can't sign

Relationship to Patient

Address

Phone