

LAKES ORTHOPAEDIC SPECIALISTS, P.A.

PATIENT INFORMATION
"This information is confidential"

NOTES TO BILLING:

- Insurance Change
- Address Change
- Family Members Noted
- Other Information, Explain: _____

Today's Date: _____

Patient Name – Last, First, MI
Address

City – State – Zip Code	Home Telephone
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Sex Male Female	Age	Date of Birth	Social Security Number	Marital Status (Circle One) Minor/Child Single Married Widowed Divorced
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Date of Injury	Cell Phone
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****** NOTE – If your care is Work Related or due to an Auto Injury, COMPLETE the form for this important information – see the Receptionist. If you are working with an attorney or expect to, please give us their name, address and telephone number.**

Employer	Occupation	Business Telephone Number
Spouse's Name	Spouse's Employer	Spouse Business Telephone No.

****** IF PATIENT IS A MINOR, PLEASE FILL OUT PARENT/GUARDIAN INFORMATION BELOW ******

Father	Employer	Business Telephone
Mother	Employer	Business Telephone

Local Friend/Relative <u>not</u> at same address	Telephone ()	Relationship
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If Applicable

How did you select our Clinic? Physician Friend/Patient-Name _____ Yellow Pages Other: _____
 If Physician: Name _____ Clinic _____ Telephone _____
 Address _____ City _____ State _____ Zip Code _____

I hereby authorize you to release medical information about me to the following Physician/Clinic:

INSURANCE INFORMATION – Please show your card to the receptionist. If you are unable to provide this information, you will be responsible for filing claims to your insurance company.

Primary Insurance	Group #	Policy #	Policy Holder Name	Policy Holder Date of Birth:
Insurance Company Address	City	State	Zip Code	Telephone
Secondary Insurance	Group #	Policy #	Policy Holder Name	Policy Holder Date of Birth:
Insurance Company Address	City	State	Zip Code	Telephone

- ❖ **Treatment Authorization** – I hereby authorize LAKES ORTHOPAEDIC SPECIALISTS, P.A., or their designee(s), to treat my or the patient's condition as they deem appropriate.
- ❖ **HIPAA Privacy Act** – I have received the HIPAA Privacy Practice Act from LAKES ORTHOPAEDIC SPECIALISTS, P.A..
- ❖ **Assignment of Benefits** – I hereby assign the authorized benefits and direct that payment under any insurance policy or health benefits plan to be made directly to LAKES ORTHOPAEDIC SPECIALISTS, P.A. for any services rendered to me by or on behalf of LAKES ORTHOPAEDIC SPECIALISTS, P.A..
- ❖ **Medicare Patients** – I request that payment of authorized Medicare benefits be made either to me or on my behalf to LAKES ORTHOPAEDIC SPECIALISTS, P.A. for any services furnished me by that organization. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.
- ❖ **Records Release to Insurance Carrier(s) and Other Payers** – I hereby authorize LAKES ORTHOPAEDIC SPECIALISTS, P.A. to release to my insurance company, health plan, HMO, no-fault carrier, and/or workers' compensation carrier, any information including my complete health record needed to determine benefits for services provided by or on behalf of LAKES ORTHOPAEDIC SPECIALISTS, P.A..
- ❖ **"I understand that I am financially responsible for charges not covered under my insurance policy".**

FOR ALL OF THE ABOVE INFORMATION: _____
SIGNATURE DATE