

# SOUTHERN ORTHOPAEDIC SPECIALISTS

**OFFICE USE ONLY:**

CHART # \_\_\_\_\_ ACCOUNT # \_\_\_\_\_  
 INSURANCE ( PRIMARY ) : CO-PAY \$ \_\_\_\_\_ DED \$ \_\_\_\_\_ OUT-OF-POCKET \$ \_\_\_\_\_  
 ( SECONDARY ) : CO-PAY \$ \_\_\_\_\_ DED \$ \_\_\_\_\_ OUT-OF-POCKET \$ \_\_\_\_\_

NAME \_\_\_\_\_ NEW PATIENT YES NO  
 LAST FIRST MI MARITAL STATUS MARRIED/SINGLE/WIDOWED  
 ADDRESS \_\_\_\_\_ CONDITION NEW OLD  
 ADDRESS CITY/STATE/ZIP DATE OF BIRTH \_\_\_\_\_  
 PHONE: ( HOME ) \_\_\_\_\_ PROBLEM TODAY \_\_\_\_\_  
 ( WORK ) \_\_\_\_\_ DATE OF INJURY/ACCIDENT \_\_\_\_\_  
 ( E-MAIL ) \_\_\_\_\_ DO YOU HAVE OTHER INSURANCE? YES NO  
 SOC. SEC. # \_\_\_\_\_  
 EMPLOYER: \_\_\_\_\_ OCCUPATION \_\_\_\_\_

NOTIFY IN EVENT OF EMERGENCY \_\_\_\_\_  
 NAME PHONE RELATIONSHIP

**\*\*Southern Orthopaedic Specialists will be happy to file initial claim to your medical insurance carrier. As a courtesy, our office will follow-up w/ an appeal to the carrier. If these efforts do not generate payment in a timely manner, Southern Orthopaedic Specialists will provide patient with the necessary paperwork to file their medical claim\*\***

INSURANCE ( PRIMARY ) \_\_\_\_\_ INSURED'S SS# \_\_\_\_\_  
 INSURED'S NAME ( IF OTHER THAN PT ) \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
 INSURED DATE OF BIRTH \_\_\_\_\_ I.D.# \_\_\_\_\_ GROUP # \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_  
 NAME ADDRESS CITY/STATE/ZIP PHONE

INSURANCE ( SECONDARY ) \_\_\_\_\_ INSURED'S SS# \_\_\_\_\_  
 INSURED'S NAME ( IF OTHER THAN PT ) \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
 INSURED DATE OF BIRTH \_\_\_\_\_ I.D.# \_\_\_\_\_ GROUP # \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_  
 NAME ADDRESS PHONE

**HOW DID YOU HEAR ABOUT SOUTHERN ORTHOPAEDIC SPECIALISTS?**  
 PRIMARY CARE PHYSICIAN \_\_\_\_\_ OTHER PHYSICIAN \_\_\_\_\_  
 FRIEND/RELATIVE \_\_\_\_\_ ADVERTISING \_\_\_\_\_  
 WHAT WOULD MAKE YOUR VISIT WITH THE DOCTOR A MORE PLEASANT EXPERIENCE?  
 \_\_\_\_\_  
 WOULD YOU BE INTERESTED IN SATURDAY HOURS FOR OFFICE VISITS? YES NO

**Authorization to Pay Benefits to Physician:** I hereby authorize payment of medical benefits directly to Southern Orthopaedic Specialists. I understand that co-payments, deductibles, out-of-pocket expenses, non-covered services, and balances due after insurance payments are due at the time of service, unless prior arrangements have been made w/ the office administrator. S.O.S. will bill my insurance for services rendered. I understand payment is due w/in 30 days of receipt of this claim form. If my insurance does not pay w/in 30 days, I understand I am responsible for payment of the bill and/or contacting my insurance company to secure payment. S.O.S. will notify me if my Plan requires further information or other medical records. A photocopy of this authorization may be honored as valid. This authorization is valid until revoked by me in writing.

**Authorization to Release Information:** I hereby authorize Southern Orthopaedic Specialists to release any medical information necessary to process any insurance claim. These may be in the form of copies of medical records or information conveyed via telephone or telefax, to my insurance company and/or any referral provider and/or any other necessary third party and/or its agents (collectively referred to as "the Plan"). I also authorize this facility to disclose any medical information necessary to the Plan to verify services, conduct quality, chart, site, or utilization reviews, investigate grievances. Your Plan may need information to pre-certify services, medication, medical equipment, or physical therapy. The Plan may review your financial records. The Plan may review your medical chart in our office for proper documentation or for their studies as a measure of quality. Your referring physician will receive a copy of your chart notes regarding your visit. This authorization also releases to the Health Care Financing Administration (HCFA) or its medical claims agencies any information needed to administer Title XVIII (the Medicare Program) of the Social Security Act. A photocopy of this authorization may be honored as valid. This authorization is valid until revoked by me in writing.

Patient's Signature (For Minor, Parent or Guardian) \_\_\_\_\_ Patient's Full Name (Print) \_\_\_\_\_ Today's Date \_\_\_\_\_