

SOMERS ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP, P.L.L.C.

664 Stoneleigh Ave., Ste. 300
Carmel, NY 10512
(845) 278-8400

400 Westage Bus. Ctr. Dr.
Ste. 106
Fishkill, NY 12524
(845) 227-2228

657 E. Main St., Ste. 3
Mt. Kisco, NY 10549
(914)666-5550

2 Victory Court
Newburgh, NY 12550
(845)565-1454

40 Old Ridgebury Rd.
St. 100
Danbury, CT 06810
(203) 894-4185

PATIENT REGISTRATION FORM

PLEASE PRINT CAREFULLY

Confidential

PATIENT NAME _____

DATE OF BIRTH _____ AGE _____ SEX _____ SOCIAL SECURITY _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

ADDRESS: _____
MAILING ADDRESS / STREET _____ APT No. _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE: HOME #: () - MOBILE #: () -

EMAIL ADDRESS: _____ MAY WE EMAIL YOU? () YES () NO

EMPLOYER / OCCUPATION _____

ADDRESS: _____
MAILING ADDRESS / STREET _____ APT No. _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE: () - EXTENSION: _____

EMERGENCY CONTACT _____ TELEPHONE: () -
PRINT NAME & RELATIONSHIP

SPOUSE <i>(If you are covered under your Spouse's Insurance)</i>
NAME _____
DATE OF BIRTH ____ / ____ / ____
SOCIAL SECURITY # _____
EMPLOYER _____
TELEPHONE () - _____

PARENT / LEGAL GUARDIAN <i>(For Minors)</i>
NAME _____
DATE OF BIRTH ____ / ____ / ____
SOCIAL SECURITY # _____
EMPLOYER _____
TELEPHONE () - _____

If you think you may be Pregnant, please inform the Physician.

First Name: _____ Middle Initial ____ Last Name _____

Date Of Birth: _____

Date of Appointment: _____ MD: _____

SOMERS ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP, P.L.L.C.

PATIENT REGISTRATION FORM

PLEASE PRINT CAREFULLY

Confidential

INSURANCE INFORMATION

We will need a copy of your Insurance Card(s). Please present your Insurance Card(s) to the Receptionist.

PRIMARY INSURANCE	
PLAN	_____
ID / POLICY #	_____
SUBSCRIBER	_____
	(SELF or PRINT NAME & RELATIONSHIP)
ADDRESS	_____

SECONDARY INSURANCE	
PLAN	_____
ID / POLICY #	_____
SUBSCRIBER	_____
	(SELF or PRINT NAME & RELATIONSHIP)
ADDRESS	_____

Complete If Your Injury Is Work - Related

WORKER'S COMPENSATION CARRIER		
ADDRESS	_____	

EMPLOYER	_____	
CASE REPRESENTATIVE	_____	
CARRIER CASE #	_____	
WORKERS COMP. BOARD #	_____	
DATE OF INJURY	/	/
BODY PART	RT	LT

Complete if your injury resulted from an automobile accident

NO FAULT CARRIER		
ADDRESS	_____	

POLICY HOLDER	_____	
POLICY #	_____	
ATTORNEY	_____	
FILE #	TEL #	_____
DATE OF ACCIDENT	/	/

First Name: _____ Middle Initial ____ Last Name _____
Date Of Birth: _____
Date of Appointment: _____ MD: _____

SOMERS ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP, P.L.L.C.

OUR PRACTICE PAYMENT POLICY

MANAGED CARE / HMOs

We participate with most HMOs. It is the Patients or Authorized Representative (Parent or Legal Guardian for Minors) responsibility to provide Somers Orthopaedic Surgery & Sports Medicine Group, P.L.L.C. with his or her insurance information, Copy of the Insurance Card(s) and Referral. If the Referral is not available at the time of visit, then you will be required to pay for the visit. If you are able to obtain a valid Referral after the visit, you will be reimbursed for the payment (less co-pay) you made for the services rendered. Payment for co-pay's will be collected at each visit.

MEDICARE

Our participation in Medicare includes Physician and X-Ray Services. Medicare Patients are responsible for payment of the Medicare 20 % Co-insurance and the Medicare Deductible when applicable.

WORKERS' COMPENSATION / NO - FAULT

It is the Patients responsibility to bring all Workers' Compensation / No - Fault Insurance and Attorney Information with them at the time of the visit.

PRIVATE INSURANCE

If you are not covered under any of the above Insurance Plans, Payment for the Initial Consultation Fee, Office Visit and / or X-Ray(s) is required on the day of your appointment. We will mail you an itemized Receipt to submit for Reimbursement to your Insurance Company if requested.

UPDATES

It is the patient's responsibility to notify Somers Orthopaedic immediately of any change in their insurance or Employment Status to ensure accurate submission of claims.

PAYMENT

Payment may be made by cash, Check or Credit Card. We accept American Express, Discover, MasterCard and Visa.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS:

I have completed this Patient Registration Form and state that all of the information I have provided is valid and true. I have read and understand the Payment Policy of Somers Orthopaedic Surgery & Sports Medicine Group, P.L.L.C.

I understand that payment is due on the date service are rendered and that if my Insurance Carrier does not pay the balance in full, I am personally responsible for the remaining Balance and I will pay any Balance promptly.

I hereby authorize Somers Orthopaedic Surgery & Sports Medicine Group, P.L.L.C. to release any information acquired by them for purposes of Treatment, Payment and Healthcare Operations. I hereby authorize Payment(s) to go directly to Somers Orthopaedic Surgery & Sports Medicine Group, P.L.L.C.

PATIENT NAME: _____ **D.O.B.** _____

AUTHORIZED REPRESENTATIVE / PARENT / LEGAL GUARDIAN _____
(PRINT NAME & RELATIONSHIP)

SIGNATURE _____ **DATE** _____
PATIENT / AUTHORIZED REPRESENTATIVE / PARENT / LEGAL GUARDIAN - For Minors

First Name: _____ Middle Initial ____ Last Name _____

Date Of Birth: _____

Date of Appointment: _____ MD: _____

SOMERS ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP, P.L.L.C.

Confidential

AUTHORIZATION QUESTIONNAIRE

PLEASE PRINT CAREFULLY

AUTHORIZED REPRESENTATIVE(S):

Please list the family members or other persons, if any, whom we may inform about your general medical condition & your diagnosis (including treatment, payment and healthcare operations) and who may pick up copies of medical records, radiology films, prescriptions and receive telephone calls such as appointment reminders on your behalf.

Spouse: _____ Other: _____

Parent: _____

Son / Daughter: _____

EMERGENCY CONTACT(S):

Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

Name: _____ Telephone Number: () - _____

Name: _____ Telephone Number: () - _____

Name: _____ Telephone Number: () - _____

BILLING / CORRESPONDENCE:

Please print the address of where you would like your billing statements and / or correspondence from our office to be sent **if other than your home address:**

Address: _____

TELEPHONE MESSAGES / APPOINTMENT REMINDERS

Please print the telephone number where you would like to receive calls about your appointments, test results, or other health care information **if other than your home telephone number:**

Telephone Number: () - _____

Telephone Number: () - _____

Please be aware that a cell phone is not a secure and private line.

It is our office policy to call scheduled patients to confirm appointments. May we leave messages such as appointment reminders on your telephone answering machine (at home) or voicemail (at work)?

Yes No

PATIENT NAME: _____

PARENT / LEGAL GUARDIAN: _____
(if minor)

SIGNATURE OF PATIENT / PARENT / GUARDIAN: _____

First Name: _____ Middle Initial ____ Last Name _____

Date Of Birth: _____

Date of Appointment: _____ MD: _____

SOMERS ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP, P.L.L.C.

ACKNOWLEDGEMENT

I hereby acknowledge receipt of the Notice of Privacy Practices.

Signature

Print Name

Date

* This acknowledgement reflects the proposed modifications to § 164.520 of the privacy standards as set forth by the Department of Health and Human Services at 67 Fed. Reg. 14814 (March 27, 2002). It applies to health care providers with direct treatment relationships. This acknowledgement, or some other form of acknowledgement (e.g., initials), can be on a cover sheet to be retained by the provider, on a separate list apart from the notice, or otherwise.