Patient#: _____

ORTHOPEDIC CENTER
of Palm Beach County

PATIENT INFORMATION

Name:	Date of Birth:	Sex:
Address One:	Social Security #:	
Address Two:	Marital Status:	
City:	Language:	
State: Zip:	Employer:	
Home Phone#:	Emergency Contact:	
Work Phone#:	Emergency Phone#:	
Cell Phone#:	Emergency Relationship:	
Student: □ Not a student □ Full-time □ Part-time	Email:	
Referring Physician:	Primary Physician:	
Referring Physician Phone#:	Primary Physician Phone#:	

GUARANTOR INFORMATION

Name:	Date of Birth:	Sex:
Address One:	Social Security#:	
Address Two:	Relationship to Patient:	
City:	Employer:	
State: Zip:	Employer Address:	
Home Phone#:	Employer City:	
Work Phone#:	Employer State: Zip:	
Cell Phone#:	Email:	

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate#:	Certificate#:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:

RACE/ETHNICITY

Race: □ White □ Black/African American □ Native Hawaiian □ Other Pacific Islander
□ Asian □ Native American/Alaska Native □ More than 1 race □ Prefer to not disclose

Ethnicity: □ Hispanic / Latino □ Not Hispanic / Latino □ Prefer to not disclose □ Other

Patient#: _____

PHARMACY INFO

Pharmacy Name:	**Pharmacy Phone#:**

REFERRAL SOURCE

Please check one:

□ **Athletic Trainer** □ **Friend** □ **Family Member** □ **Internet** □ **Insurance**
□ **Self** □ **MD Now** □ **Med Express** □ **Urgent Care**
□ **Physician's Name: _____**

Payment Guarantee: The undersigned patient and guarantor, if any, hereby agree to pay all OCPBC charges to the OCPBC in accordance with the regular rates and terms of the OCPBC and agree to pay for any charges not covered by any third party payer. The Medical Practice files insurance as a courtesy to the patient, but the patient is ultimately responsible for payment of the total incurred charges. The undersigned agree that if this account is turned over to a collection agency or attorney, that the undersigned patient and guarantor, if any, shall be obligated to pay the outstanding balance plus all costs of collection including reasonable attorney fees. The undersigned agree that any overpayments collected on this account may be applied directly to any delinquent account for which the undersigned patient is legally responsible. The undersigned patient and guarantor, if any, hereby agree that they are jointly and severally liable to pay the entire balance due and that the OCPBC is relying upon the undersigned(s) to pay in treating the patient.

Consent to Medical and Surgical Treatment: The undersigned hereby consents to all medical care and services, surgical treatment, examinations, tests and procedures, including but not limited to x-ray examination, laboratory and diagnostic procedures and tests, anesthesia, which a Physician, their employees, nurses, associates or designees may deem advisable to the undersigned patient during this treatment.

Assignment of Insurance Benefits: I hereby authorize payment directly to the Orthopedic Center of Palm Beach County, (hereinafter referred to as "OCPBC") and assign to them any and all rights and benefits that I or the patient may have under any policy of insurance including medical, automobile, personal injury protection, workers compensation, or any other coverage and further direct any such insurance company to make payment of benefits directly to OCPBC. I understand that I am financially responsible to OCPBC for charges not covered by this assignment.

Lifetime Signature Authorization: I hereby authorize OCPBC to furnish to my insurance company or their representative, or Social Security Administration or the Center for Medicare and Medicaid, or Medigap or its intermediaries or to the billing agent of OCPBC any information needed for this claim or related claims. I permit a copy of this authorization to be used in place of the original.

Notice of Privacy Practice: I have been provided information by the OCPBC regarding their privacy practices.

Patient Name: _____

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Relationship to Patient: _____ Date: _____

If patient is under age 18, I hereby give my permission for _____ to be treated by OCPBC.