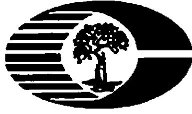

ORTHOPAEDIC, SPORTS MEDICINE AND REHABILITATION CENTER, P.A.

Middletown Office
80 Oak Hill Road
Red Bank, New Jersey 07701
Phone 732-741-2313 / Fax 732-741-7154

Marlboro Office
Kilmer Professional Park - Building 3
25 Kilmer Drive - Suite 104
Morganville, New Jersey 07751
Phone 732-617-9111 / Fax 732-617-5959

www.orthocenter.com

PATIENT INFORMATION

(Please note the information being requested is for the PATIENT)

Patient Name: ______________________________ Sex: M F DOB: __________ Age:____

Home Phone: (_____) _____-_________ Cell Phone (_____) ______-________

Home Address: ______________________________ Social Security # ________________

City: __________________ State: _______ Zip: _______ Marital Status: S M W D

Email address: ______________________________ Race: _____Ethnicity: __________

Employer's Name: ________________________________Phone# ________________

IF PATIENT IS UNDER 18 YEARS OF AGE, Responsible Party Information

Responsible Party Name: _________________________ Sex: M F DOB: ____________

Relationship to the patient: _________________ Social Security # ____________________

Billing Address: ______________________________ Phone:(____) ______ -__________

City: __________________State:_______Zip:_________

PRIMARY INSURANCE INFORMATION

Subscriber Name: ____________________________ Sex: M F DOB: ________________

Subscriber home address: ____

Relationship to patient: ______________________ Social security # ____________________

Insurance Name: ___________________________ Policy # _________________________

Claims Address: ___________________________ Group # _________________________

City: ________________ State:________ Zip:__________ Phone# (____) _____-__________

PLEASE TURN OVER ....

Patient Information cont'd…

SECONDARY INSURANCE INFORMATION:

Subscriber Name: ________________________________ Sex: M F DOB: __________________

Subscriber home address: ____

Relationship to patient: _________________________ Social security # _____________________

Insurance Name: ______________________________ Policy # ____________________________
Claims Address: ______________________________ Group # ____________________________
City: _________________ State:________ Zip:__________ Phone# (____) _____-____________

First/Last Name of Primary Care Physician:

____

First/Last Name of Referring Physician:

____

Please complete if your visit today is a result of an accident. Type of Accident:

[ ] Auto Accident [ ] Workers Comp Accident

[ ] Slip and Fall Accident [ ] Sports Related Accident [ ] Assault/Battery

Date of Accident: _____/_____/______ Location of Accident: (City/State) ___________________

If Sports Related Accident, name of school you attend: _____________________________________

Name of Attorney representing you: ____

( ) I authorize the release of any information required in the processing of my health claims

( ) I authorize my insurance benefits to be paid directly to the health care provider

____ ______/_____/_____

Patient/Guardian Signature Date

Rev.3-26-2019

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FINANCIAL POLICY AND INSURANCE AUTHORIZATION

I authorize Orthopaedic, Sports Medicine and Rehabilitation Center, PA ("OSMRC") to release to the Social Security Administration and Centers for Medicare & Medicaid Services, its intermediaries or carriers, or to any other insurance company for which I or my dependents or insurance beneficiaries is/are covered insureds, any information, including protected health information, needed for processing of claims for payment for services rendered to me or my dependents or insurance beneficiaries, as applicable. I request that payment of Medicare and/or other third-party insurance company benefits for services rendered to me (or my dependents or insurance beneficiaries, as applicable) be made directly to OSMRC. If my insurance carrier will not assign benefits to OSMRC, then I understand that I am responsible for payment of all charges, regardless of whether or not I am later reimbursed by my insurance plan.

<u>We are providers for some insurance plans</u> and we will bill your insurance company directly. Most plans require co-payments and/or deductibles and co-insurance that are due at the time of service.

<u>If we are not a participating provider with your insurance plan, or you do not have insurance</u>, payment is expected in full at the time of service.

<u>If your visit is a result of a work injury or motor vehicle accident</u>, you must provide us with the following information prior to your visit: insurance carrier, claim number, adjuster's full name and phone number, and date of accident. If your visit is not authorized by this insurance carrier, you will be fully responsible for services rendered.

<u>***I understand that I am responsible for all deductible, co-payment, co-insurance and/or charges for all non-covered services.***</u> It is customary to pay for services when rendered, unless other arrangements have been made. Acceptable forms of payment are cash, check, Visa, MasterCard, Discover, or American Express. There is a $20 administration fee for any returned check. In the event I fail to pay for services rendered, when payment is due, my account will be turned over to collection.

Please feel free to contact our Billing Office if you have any questions. We are happy to answer your questions or to provide additional information.

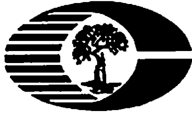
I understand and acknowledge the financial policy and insurance authorization terms stated above.

____ ________________________

Patient's Name **Date**

____

Signature (Patient/Parent/Guardian)



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HIPAA/PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

The Orthopaedic Center is very concerned about the protection of your health information. Federal law is requiring all physician offices to have a signed privacy statement on file for every patient. In order to serve you, we must have an existing Privacy Acknowledgement form on file. The law is intended to protect the privacy of your medical records. – Thank you.

I have been given the opportunity to review the Notice of Privacy Practices.

Patient Name: ______________________________ DOB: ______________

Signature: ______________________________ Date: ______________

Patient's Personal Representative & Relationship ______________________________

Any and all situations can be discussed with ______________________________

In case of emergency, please contact:

Name: ______________________________

Phone Number: ______________________________

☐ I do, ☐ I do not give permission to The Orthopaedic Center to leave detailed messages on my answering machine, mail to my home or fax any information regarding appointments, instructions for surgery, test results, billing and/or insurance issues or other pertinent information.

Fax #: ______________________________

______________________________ ______________

Patient Signature Date