

**PLEASE COMPLETE THIS FORM AND RETURN IT TO THE RECEPTIONIST PROMPTLY.  
IF THIS IS A WORK RELATED INJURY OR AUTO ACCIDENT, PLEASE COMPLETE THE ATTACHED ACCIDENT FORM.**

Do you have Medicare? (Circle one) **YES NO** Medicare Replacement? **YES NO**  
**PATIENT INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_  
 GOES BY: \_\_\_\_\_ DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_-\_\_\_-\_\_\_ Marital Status \_\_\_\_\_  
 HOME ADDRESS: \_\_\_\_\_  
 BILLING ADDRESS: (if different) \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ GENDER: **M F** Spouse's Name: \_\_\_\_\_  
 Home Phone#: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone#: ( ) \_\_\_\_\_ - \_\_\_\_\_ email: \_\_\_\_\_  
 Employer Name: \_\_\_\_\_ Phone#: ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**INSURANCE INFORMATION**

\_\_\_\_\_ PPO \_\_\_\_\_ HMO \_\_\_\_\_ POS  
 PRIMARY Insurance: \_\_\_\_\_  
 SUBSCRIBER (if different than patient): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Subscriber's DOB: \_\_\_/\_\_\_/\_\_\_ Policy/Membership# \_\_\_\_\_ Group #: \_\_\_\_\_  
 SECONDARY Insurance: \_\_\_\_\_  
 SUBSCRIBER (if different than patient): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Subscriber's DOB: \_\_\_/\_\_\_/\_\_\_ Policy/Membership# \_\_\_\_\_ Group #: \_\_\_\_\_

**PERSON FINANCIALLY RESPONSIBLE FOR PAYMENT (if other than patient)**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 SS# \_\_\_/\_\_\_/\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_

**EMERGENCY CONTACT**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Home Phone#: ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Other: ( ) \_\_\_\_\_ - \_\_\_\_\_

REFERRING PHYSICIAN:  
 Who may we thank for referring you to our office? \_\_\_\_\_

**PLEASE COMPLETE FRONT & BACK OF THIS FORM.**

## AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

SCG – Orthopaedics is authorized to release any medical records pertinent to the healthcare of the above named patient to, but not inclusive of, any insurance carrier, adjustor, attorney, health care provider, or immediate family member, upon receipt of the signature of the above named patient or the signature of the patient's legal guardian. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage (in the event that claims are submitted to an insurance company on your behalf) for services rendered by any physician of SCG – Orthopaedics.

**LIST NAME OF PERSON (S) WHOM WE MAY DISCUSS ACCOUNT INFORMATION OTHER THAN THE PATIENT:** \_\_\_\_\_

### FINANCIAL POLICY

**\*We participate in most insurance plans, including Medicare.**

1. It is your responsibility to check with your plan prior to your visit to make sure we are participating physicians. Failure to do this could result in reduced payments by your insurance company.
2. We do not file automobile, general liability, or homeowner's insurance.
3. If you have HMO/POS insurance, it is your responsibility to obtain a referral number from your PCP prior to being seen. If you fail to obtain this, the bill is your responsibility.

**\*You and your insurance company are responsible for your bill.**

1. We realize that insurance requirements are confusing, but knowing your insurance benefits is your responsibility.
2. Any questions concerning your coverage should be directed to your insurance company.
3. We will file secondary insurance, but if the secondary insurance denies payment, you are responsible for the balance.

**\*If your primary insurance company requires a co-payment, you must make the co-payment at the time of service.**

1. Failure to pay your co-pay at the time of service will result in a billing fee of **\$25.00**. Please remember that we are contractually obligated by your insurance company to collect your co-pays at time of service.
2. The balance of your charges will be billed to your insurance company. After payment of insurance company, any remaining balance will become patient responsibility, which is due upon receipt of statement.
3. If payment of any service results in a credit balance on either entity, the credit balance will first be applied to any outstanding balance you have before being refunded to you.

**\*Proof of current, valid insurance must be provided at time of service.**

1. If you do not provide this information, you will be considered a self-pay patient.
2. Self-pay patients are required to pay their office visit charges in full. Please ask about your advance payment responsibility when making your appointment.
3. Failure to pay your office visit charges at the time of service will result in a billing fee of \$25.00.
4. You will be billed for the balance of your charges. Payment in full will be expected with receipt of your statement.

**\*Failure to receive your statement does not relieve you of your financial obligation. It is your responsibility to notify us of any changes in your billing information.**

**\*We accept cash, checks, money orders and major credit cards.**

1. Returned checks are subject to a \$35.00 return check fee, which **MUST** be paid before return appointments can be scheduled.

**\*Past due accounts are subject to our collections process. Any fees assessed by a collection agency will be added to the balance.**

### PRESCRIPTION POLICY

Prescriptions and refills for medications are issued during office hours only. 8:30 am to 5:00 pm, Monday thru Friday. No medications will be refilled over the phone after hours or on weekends. If you have an emergency situation, you will be directed to the emergency department of the local hospital. During the course of treatment with our office, do not obtain pain medications from any other source.

\_\_\_\_\_  
PATIENT NAME (PRINT & SIGN)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PERSON RESPONSIBLE FOR PAYMENT

\_\_\_\_\_  
DATE

RELATIONSHIP TO PATIENT: \_\_\_\_\_