

ROCKY MOUNTAIN ORTHOPAEDIC ASSOCIATES, P.C.

PLEASE USE BLACK OR BLUE PEN ONLY

PATIENT'S DEMOGRAPHIC, FINANCIAL & INSURANCE INFORMATION- SECTION ONE

NAME: Last: _____ First: _____ MI: _____ SSN: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Other Phone: _____ Date of Birth: _____ Age: _____

Sex: Male Female Marital Status: Single Married Divorced Legally Separated Widowed

Dependent Status: N/A Dependent Child under 18 Full-time Student over 18 Part-time Student over 18

Your Occupation: _____ If retired, date you retired _____ / _____ / _____

Employer: _____ Address: _____ Work Phone: _____ EXT _____

Nearest relative **NOT** living with you: _____ Phone: _____

Relationship: _____

If married:

Spouse's name: _____ Date of Birth: _____ / _____ / _____ SSN: _____ - _____ - _____

Spouse's Occupation: _____ Employer: _____ Work Phone: _____

FEES & PAYMENTS / BILLING INFORMATION - SECTION TWO

You can help keep down the cost of your medical care by paying your portion due for services upon completion of each visit. Other arrangements can be made with our office depending on special circumstances. The guarantor on this account is ultimately responsible for all charges not paid by the insurance company or other third party.

Who is responsible (the guarantor) for this account? Self Father Mother Other legal guardian

Guarantor Information (If self, skip to next section)

NAME: _____ Relationship _____ SSN: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Employer: _____ Work Phone: _____

MEDICAL PLAN / INSURANCE INFORMATION - SECTION THREE

A copy of your medical insurance card or State Medicaid card is required for billing. It is very important that all information be filled out completely and accurately, Insurance is considered a contract between the patient and the insurance company for reimbursement of certain medical fees. If you have medical insurance, we will bill the insurance company. However, it is your responsibility to pay deductibles, co-pays, or balances not paid by the insurance within a reasonable time.

Is your insurance an employer paid plan: Yes No

PRIMARY MEDICAL INSURANCE - COMPANY NAME: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Insured: Self Spouse Other: _____ Insured Birth Date: _____ / _____ / _____ Policy #: _____

SECONDARY MEDICAL INSURANCE - COMPANY NAME: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Insured: Self Spouse Other: _____ Insured Birth Date: _____ / _____ / _____ Policy #: _____

INITIAL REASON FOR APPOINTMENT - SECTION FOUR

This section must be completed EACH time you are seen for a new ailment. What is the reason for your appointment:

Date: _____ **Ailment / Complaint:** _____ **Body Part (s):** _____

Result of accident? No Yes (complete accident report) **Bill to:** _____

Referred by: _____ Referral on File: No Yes **Patient's Initials:** _____ **Intake Initials:** _____

Date: _____ **Ailment / Complaint:** _____ **Body Part (s):** _____

Result of accident? No Yes (complete accident report) **Bill to:** _____

Referred by: _____ Referral on File: No Yes **Patient's Initials:** _____ **Intake Initials:** _____

Date: _____ **Ailment / Complaint:** _____ **Body Part (s):** _____

Result of accident? No Yes (complete accident report) **Bill to:** _____

Referred by: _____ Referral on File: No Yes **Patient's Initials:** _____ **Intake Initials:** _____

Date: _____ **Ailment / Complaint:** _____ **Body Part (s):** _____

Result of accident? No Yes (complete accident report) **Bill to:** _____

Referred by: _____ Referral on File: No Yes **Patient's Initials:** _____ **Intake Initials:** _____

Notice of Privacy Practices

I have received a copy of Rocky Mountain Orthopaedic Associates, PC Notice of Privacy Practices

Signature of Patient or Designated Representative

Date

Relationship to Patient

Parent or Legal Guardian Information

Name: _____ **Relationship:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

(Enter same if same as patient)

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

I understand that I am responsible for all charges whether or not covered by insurance. I agree to pay all attorney fees and costs incurred by RMOA to collect any unpaid balance. I certify that the information I furnished is true and correct.

AUTHORIZATION FOR PAYMENT

I hereby irrevocably assign to the physician all payments for medical services rendered and authorize payment of medical benefits directly to the physician. I understand that I am financially responsible for all charges whether or not covered by insurance. I agree to pay all attorney fees and costs incurred by Rocky Mountain Orthopaedic Associates to collect any unpaid balance. I certify that the information I furnished is true and correct.

Signature: _____

(signature of patient or legal guardian if patient is a minor)

Date: _____