

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_  
Last First MI

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_ Email address: \_\_\_\_\_

Employer/School Name: \_\_\_\_\_

Employer/School Name & Address: \_\_\_\_\_

**Patient Sex:** M or F **Marital Status:** S M D W Sep **Employment Status:** Full-time Part-time Retired

Was this an accident? Yes or No [ ] Work [ ] Auto [ ] Home [ ] Sports [ ] Other  
What was the date of injury? \_\_\_\_\_

**INSURANCE COVERAGE: YES NO** If yes, Name of Primary Company: \_\_\_\_\_  
If have Secondary Insurance: \_\_\_\_\_ If have an HSA: \_\_\_\_\_

**INSURED PERSON INFORMATION – IF DIFFERENT FROM ABOVE**

Patient Name: \_\_\_\_\_  
Last First MI

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_ Email address: \_\_\_\_\_

Patient Employer/School Name: \_\_\_\_\_

Employer/School Address: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**SPOUSE INFORMATION, IF MARRIED**

Name: \_\_\_\_\_  
Last First MI

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

**EMERGENCY Contact Name and Relationship:** \_\_\_\_\_

**EMERGENCY Contact Phone Number:** \_\_\_\_\_

**FINANCIAL POLICY**

**INSURANCE BILLING**

- I hereby give my consent to bill my insurance company for services rendered-by the physicians from Lakeshore Bone & Joint Institute
- I understand that all deductibles, co-pays and patient balances are payable at the time of service.
- I acknowledge responsibility to inform the office of any changes in my insurance coverage and to obtain any referrals or authorizations prior to treatment.

**MEDICARE PATIENTS**

- I hereby assign payment of authorized **MEDICARE benefits and ANY OTHER MEDICAL AND OR SURGICAL BENEFITS INCLUDING MAJOR MEDICAL BENEFITS** to which I am entitled, to be made on my behalf to Lakeshore Bone & Joint Institute for any services furnished to me by their physicians.
- I authorize Lakeshore Bone & Joint Institute to release any information needed to determine these benefits payable for related services: This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

**AUTOMOBILE ACCIDENTS/THIRD PARTY LIABILITY/ATTORNEYS CLAIMS**

- I understand that Lakeshore Bone & Joint Institute does not participate directly with automobile insurance, third party liability insurance, nor will they bill my attorney for patient balances, which are my responsibility.
- My debt to Lakeshore Bone & Joint Institute is not contingent on any claim against a third party or liability carrier,

**WORKERS' COMPENSATION PATIENTS**

- I understand that Lakeshore Bone & Joint Institute participates with my Workers' Compensation insurance for accepted injuries, providing I have given all necessary information needed to bill for services provided to me. The information necessary for Workers' Compensation billing includes but is not limited to claim number, insurance carrier and address, employers name, address, telephone number and date of injury.
- If my Workers' Compensation claims are later denied, I understand that it is my responsibility to provide payment in full for services rendered.
- My signature authorizes the release of my medical records to the Workers' Compensation carrier or agent as required by current Workers' Compensation Laws. It also authorizes release of my work status to my employer upon their or my request.

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**Documentation of consent to terms this page, acknowledgement of age and collection fee agreement**

I understand that this authorization shall remain effective and a permanent addition to my medical records upon my signing below.

I am at least 18 years of age. If, however, the patient is under 18 years of age, I am the parent or legal guardian for the patient and hereby give consent to have my child treated by Lakeshore Bone & Joint Institute

In the event collection action becomes necessary, I agree to pay reasonable attorney's fees, legal expenses, court costs and collection costs in addition to all other sums due.

**PRINT PATIENT'S NAME:**

**DATE:**

**SIGNATURE OF PATIENT IF AT LEAST 18 YEARS OF AGE:**

**SIGNATURE OF PARENT OR LEGAL GUARDIAN:**