BBJP ORTHOPEDICS

Patient Registration Form

Patient's Name (First, Last, MI): _____ Date of Birth: _____

Patient's Home Phone Number: _____ Alternate Phone Number (☐ cell or ☐ work): _____

E-Mail Address: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Marital Status: _____ Age: _____ Sex: M F Social Security Number: _____

Patient's Employer: _____

Employment Status: [ ] Full time [ ] Part time [ ] Unemployed
[ ] Retired [] Student [ ] Other: _____

Emergency Contact: _____ Phone Number: _____

INSURANCE INFORMATION (WE WILL REQUEST TO SCAN YOUR ID AND INSURANCE CARDS)

Primary Insurance: _____ Secondary Insurance: _____

ID#: _____ ID#: _____

Gr#: _____ Gr#: _____

IS THIS WORK OR AUTO RELATED? [ ] YES [ ] NO

Insurance Company: _____ Date of Injury: _____

Address: _____ City: _____ Sate: _____ Zip: _____

Adjusters Name: _____ Phone: _____

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name(s): _____ Relationship to Patient: _____

Shoulder Stability PC reserves the right to charge a fee for any scheduled visits that are:

1. Cancelled with less than 24 hours notice
2. Are missed without calling to cancel (no show)

Cancellation Fee is $100.00

Patient / Parent or Guardian Signature: _____ Date: _____

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Authorization for Claims Payment and Reviews

1. **Assignment and Coordination of Insurance Benefits** - I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to *Shoulder Stability PC* and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the *Shoulder Stability PC* the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

2. **Unauthorized, Non-Covered, or Out of Plan Services** - I understand if my Insurance Plan(s) does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to *Shoulder Stability PC* for this admission or any service if determined by my Insurance Plan(s) to be a non -covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by *Shoulder Stability PC* .

I understand and agree this document will remain in effect for all future outpatient or physician office visits to Shoulder Stability PC .

Patient Signature: _____ Date: _____

Relationship to Patient: _____

-

I certify that I have been made aware of Shoulder Stability PC **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Shoulder Stability PC health care operations. The Notice also describes my rights and Shoulder Stability PC duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility. I may request that a copy be mailed to me by calling **425-429-7573.**

Shoulder Stability PC reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

NAME OF PATIENT OR PERSONAL REPRESENTATIVE

DATE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

SHOULDER STABILITY PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CAT #84498 / R032103
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