Orthopedic Clinic of Central Virginia, P.C.

Today's Date: _____

1201 Sam Perry Boulevard, Suite 201 • Fredericksburg, VA 22401

Patient Name: _____
Last First Middle

Address: _____
Street City State Zip

Home Phone: ( ) _____ *Cell Phone:* ( ) _____
Area Code Area Code

Work Phone: ( ) _____ *Preferred Contact Number:* ☐ Home ☐ Work ☐ Cell
Area Code

Date of Birth: _____ *Sex:* ☐ F ☐ M *Social Security Number:* _____

Employer: _____ *Employer Phone:* ( ) _____
Area Code

Address: _____
Street City State Zip

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Spouse / Significant Other: _____
Last First Middle

☐ Permitted to receive confidential/medical information

Relationship to Patient: _____ ☐ Do not disclose confidential/medical information

Home Phone: ( ) _____ *Work/Cell Phone:* ( ) _____
Area Code Circle One Area Code

Alternate Contact: _____
Last First Middle

☐ Permitted to receive confidential/medical information

Relationship to Patient: _____ ☐ Do not disclose confidential/medical information

Home Phone: ( ) _____ *Work/Cell Phone:* ( ) _____
Area Code Circle One Area Code

Responsible Party: ☐ Patient ☐ Parent ☐ Other (if other than patient, please complete below)

Name: _____
Last First Middle

Address: _____
Street City State Zip

Phone: ( ) _____ *Social Security Number:* _____
Area Code

Employer: _____ *Employer Phone:* ( ) _____
Area Code

Employer Address: _____
Street City State Zip

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Today's Date: _____

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Patient Name: _____
Last First Middle

Date of Birth: _____

Primary Insurance: _____
Name of Insurance Carrier

Name of Policyholder: _____
(if different from patient) Last First Middle

Date of Birth: _____ *Social Security Number:* _____

Secondary Insurance: _____
Name of Insurance Carrier

Name of Policyholder: _____
(if different from patient) Last First Middle

Date of Birth: _____ *Social Security Number:* _____

IS THIS VISIT? ☐ Work Related ☐ Motor Vehicle Accident Related

Work Comp/Auto Ins. _____
Name of Insurance Carrier

Address: _____
Street City State Zip

Claim # _____ *Date of Injury:* _____

Phone: (_____) _____ *Adjuster/Contact Name:* _____
Area Code

Employer at Time of Injury: _____ *Employer Phone:* (_____) _____
Area Code

Employer Address: _____
Street City State Zip

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Today's Date: _____

Patient Name: _____
Last First Middle

Date of Birth: _____

Authorization to Treat: I hereby grant permission to the physicians and staff of Orthopedic Clinic of Central Virginia, P.C. to perform any necessary procedures to treat the medical condition (s) for which I am seeking assistance. I understand that, except in an emergency, the staff will discuss with me my treatment options and that I will have the opportunity to accept or refuse treatments at that time.

Authorization to Release Information: I hereby authorize medical information about me to be released to my insurance carrier any such information that is requested by them needed for the processing of insurance benefit claims.

Assignment of Benefits: I certify that the information I have given is correct. I hereby authorize payment, of the benefits payable to me and my physician(s), to Orthopedic Clinic of Central Virginia, P.C. In applying for payment under Title XVIII of the Social Security Act, I request payment of authorized benefits be made on my behalf to those who accept this assignment. I further understand that I am responsible for any charges not covered or payable by this assignment. Even though Orthopedic Clinic of Central Virginia, P.C. accepts assignment of insurance company payments, insurance carriers occasionally send payment to the patient for services rendered by the physician. I agree to forward any such payments I receive to Orthopedic Clinic of Central Virginia, P.C. as soon as I receive them.

Prescription Monitoring Program: The Virginia Prescription Monitoring Program may be utilized to access the prescription history for Schedule II through Schedule IV controlled substances for any individual requesting services.

Charges for Services: The charges for the Orthopedic Clinic of Central Virginia, P.C. are for the physician's professional fees and services. These charges do not include surgery center or hospital facility fees. The facility fees will be billed separately by the facility.

Payment for Services: As a courtesy to you, we will file claims with your insurance company. Monthly statements are mailed to patients only if they are responsible for some portion of the bill. Patients who have no insurance coverage should be aware that payment for service is due on the day you are seen. A discount may be given for full payment on the day of your visit, and we accept payment by major credit card. We reserve the right to apply finance charges of 1.5% per month, starting from the date of service, to account balances that are outstanding for more than 30 days. Statement fees may be applied to statements for overdue balances.

Patient Responsibility for Payment: I understand that my insurance coverage is a contract between my insurance carrier and myself, not between the insurance carrier and the Orthopedic Clinic of Central Virginia, P.C. Ultimately, all fees are my responsibility. Should timely payments not be made on my account, I authorize Orthopedic Clinic of Central Virginia, P.C. to retain the services of an attorney or collection agency to assist with the collection. Any expenses incurred by the Orthopedic Clinic of Central Virginia, P.C. for such action shall become an additional liability for which I assume responsibility.

Protected Health Information: Protected Health Information (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. Our Notice of Privacy Practices describes how we may use and disclose your PHI to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to support the operation of the practice, and any other use required by law. Your signature below acknowledges that you have reviewed our HIPPA NOTICE OF PRIVACY PRACTICES, a copy of which is available upon request.

_____ _____
Patient (Parent / Guardian) Signature Date