TODAY'S DATE: _____ **PATIENT REGISTRATION** MRN# _____

LAST NAME:_____ **FIRST NAME & INITIAL**: _____
PATIENT SSN: _____ **DATE OF BIRTH:** _____
MARITAL STATUS: MARRIED/ SINGLE/DIVORCED/WIDOWED **SEX:** MALE / FEMALE
ADDRESS: _____ _____
CITY: _____ **STATE:** _____ **ZIP:** _____
PHONE HOME: _____ **CELL:** _____ **WORK:** _____
E-MAIL ADDRESS: _____
EMPLOYER: _____ **ADDRESS:** _____
OCCUPATION: _____ EMPLOYMENT STATUS: FULL TIME/PART TIME/RETIRED
SPOUSE'S NAME: _____
SPOUSE'S CELL#: _____ **WORK #:** _____

ETHNICITY: YES, HISPANIC _____ NO, NOT HISPANIC _____
RACE: ☐**AMERICAN INDIAN** ☐**ALASKAN NATIVE** ☐**ASIAN** ☐**BLACK OR AFRICAN AMERICAN**
☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER** ☐ **WHITE OR CAUCASIAN** ☐ **OTHER**
☐ **PREFER NOT TO ANSWER**

IS THIS: ☐**WORK RELATED** ☐ **RESULT OF A FALL AT** ☐**HOME** ☐ **OUTSIDE THE HOME**
SPECIFY WHERE _____
☐ **AUTO ACCIDENT**

PRIMARY INSURANCE POLICY HOLDER NAME: _____
DOB: _____ **SSN:** _____ **RELATIONSHIP:** _____
SECONDARY INSURANCE POLICY HOLDER NAME: _____
DOB: _____ **SSN:** _____**RELATIONSHIP:** _____

EMERGENCY CONTACT INFORMATION:
NAME: _____**RELATIONSHIP:** _____
HOME PHONE: _____ **CELL PHONE:** _____

DO YOU HAVE A LIVING WILL/ADVANCED DIRECTIVE? YES _____ **NO** _____
WHOM MAY WE THANK FOR REFERRING YOU: _____
PRIMARY CARE DR._____ **CARDIOLOGIST:** _____

AUTHORIZATION FOR TREATMENT - I hereby authorize the physician/nurse practitioner to conduct such examinations, perform such procedures as are medically required, and administer such treatment and medication as deemed necessary or advisable. I hereby certify that I have read and fully understand this Authorization form. I also certify that no guarantee or assurance has been made as to the results that may by obtained.

RELEASE OF INFORMATION/MEDICAL RECORD DIAGNOSIS - I hereby authorize the physician(s)/nurse practitioner(s) providing services and any other authorized person to release to its authorized billing agents, any physician who treated me, my insurance carrier, employer's workmen's compensation insurance company, or other category of third party payor, the Social Security Administration under Title XVIII(18) of the Social Security Act, the Professional Review Organization, or other intermediaries responsible for payment of my charges, a complete report of services rendered. I understand that I may revoke this consent at any time by giving written notice. I understand that if I refuse to consent to the release of information, I will be held personally responsible for payment of all charges for services rendered. **I give my consent to Munster Orthopaedic Institute, LLC and all clinical providers who have provided care to me, along with any billing service, collection agencies, attorney or other agents who may work on their behalf, to contact me on my cell phone and/or home phone using automatic telephone dialing systems or other computer assisted technology.**

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/FINANCIAL OBLIGATION - In consideration of medical services provided, I hereby assign and transfer to the physician all of my rights, title and interest to medical reimbursement, including but not limited to, the right to designate a beneficiary, add dependent eligibility and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by my physician/nurse practitioner, including Medicare Part B. I understand that I will be fully responsible for payment of any and all charges no covered by my medical insurance. I understand that if I do not pay the balance in full my account will be placed for collection and I will be responsible for all collection expenses including reasonable attorney's fees and court costs. It is our policy to charge a fee for any check that is returned due to Insufficient Funds.

CO-PAYMENTS - I understand that if my medical insurance required a co-pay or encounter fee the payment is **DUE AT THE TIME OF SERVICE.**

NO SHOW POLICY - Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences. Due to high patient demand, and limited availability of appointments we have instituted a **$25.00 no show fee for doctor appointments and $10.00 no show fee for physical therapy appointments**. By signing below, I acknowledge that I have read and understand this policy.

PRECERTIFICATION - If my insurance requires precertification it is my responsibility to make sure it is obtained. I will be held financially responsible if the precertification is not obtained.

H.H.S. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of <u>NOTICE OF PRIVACY PRACTICES:</u>

_____		_____	
Patient Signature	Date	Responsible Party Signature	Date
_____		_____	
Witness Signature	Date	Relationship to Patient	

I give consent & authorization for the medical, or billing staff of my physicians office to release information regarding my medical care to:

_____	_____
Name	Relationship
_____	_____
Name	Relationship

I understand that I may revoke this privilege listed above at any time by submitting in my request in writing to this office.

Patient/Parent/Guardian Signature: _____ Date: _____