Center of Orthopaedic & Rehab Excellence

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PATIENT INFORMATION

Patient Name: Last_____ First_____ Middle_____ Nickname_____

Patient Date of Birth: _____ Age Now: _____ Sex: _____ Race: _____ Social Security #:_____ Ethnicity_____

Home Address: _____ City: _____ St:_____ Zip: _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Phone: (_____) _____-_____ **Cell**: (_____) _____-_____ **Work**: (_____) _____-_____ **Other:** (_____) _____-_____

Retired: ____ Student: ____ Employed: ____ Employer: _____Occupation:_____

Marital Status: _____ **Spouses Name**: Last_____ First_____ Middle_____ Phone (_____) _____-_____

Responsible Party:_____ Relationship:_____ DOB:_____ Phone: (_____) _____-_____

Mailing Address (if Different than Patient):_____ City: _____St:_____ Zip: _____

Emergency Contact (**Outside of Home**):_____ Relationship: _____ **Phone**: (_____) _____-_____

Is patient in a nursing or long care facility / rehab facility? Yes____No____ If so, Where? _____

INSURANCE INFORMATION

Preferred Language: _____

Insurance Company (*Primary*): _____Contract # _____Group# _____

Subscriber Name: _____ Birthdate: _____ Relationship: _____

Employer: _____ Emp Address: _____ Emp Phone: (_____) _____-_____

Insurance Company (*Secondary*):_____Contract #_____Group#_____

Subscriber Name: _____ Birthdate: _____ Relationship: _____

Employer: _____ Emp Address: _____ Emp Phone: (_____) _____-_____

CONSENT FOR TREATMENT: I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of X-Ray, or other studies that may be used by the attending physician, nurse, or staff of C.O R.E.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize C.O.R.E. Sports Medicine to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury. I understand that C.O.R.E. Sports Medicine complies with the Alabama state requirement of reporting and reviewing Rx histories to include narcotics and controlled substances. This will include the retrieval of medication history from a third party. I authorize the query of this information. If I decline I understand I will receive no medications.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to C.O.R.E. Sports Medicine of benefits that otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the C.O.R.E. Sports Medicine charges for these services. I understand that I am financially responsible to C.O.R.E. Sports Medicine for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT: For services furnished by C.O.R.E. Sports Medicine, I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including interest and attorney's fees.

NO SHOW/CANCELLATION POLICY: There will be a minimum charge of $25.00 for all patients who miss an appointment without giving a 24 hour (one business day) notice. The $25.00 No Show/Non-Cancellation fee must be paid by each individual prior to or on the next appointment at our office. If you no show for your appointment 3 consecutive times or if you cancel less than 24 hours in advance 5 consecutive times, you will not be allowed to schedule anymore appointments at our office.

COLLECTIONS & FINANCE POLICY: All account balances not paid in full by the 20th of the month of the statement print date will be charged finance /interest charge of $50.00 or 36% whichever is higher to any unpaid balance. All unpaid accounts over 120 days will incur an additional 36% interest charge and be turned over to collections.

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. I understand that I am financially responsible for all charges whether or not paid by said insurance.

SIGNATURE_____ RELATIONSHIP_____ DATE_____