

Orthopedic Specialists of North Texas

PATIENT INFORMATION

RESPONSIBLE PARTY INFORMATION

First _____ M.I. _____ Last _____
Address _____
City, State, Zip Code _____
Home Phone _____
Business Phone _____
Sex _____ Birthdate _____
SS# _____ Marital Status _____
Driver's License # _____
Name of Bank _____
School Name _____ Full or Part Time _____
Employment Status - Employed Unemployed Retired _____
Employer Name _____
Address _____
City, State, Zip _____
Occupation _____

Responsible Party Name _____
Address _____
City, State, Zip _____
Home Phone _____
Business Phone _____
Sex _____ Birthdate _____
SS# _____
Relationship to Patient: Self Spouse Child Other _____
Employer _____
Employer Address _____
City, State, Zip _____
Phone _____
Referring Physician _____
Family Physician _____
Reason for Visit _____

INSURANCE INFORMATION

Primary Insurance _____
Address _____
City, State, Zip _____
Phone _____
Policy # _____ Group # _____
Insured's Name _____
Address/Phone _____
Sex _____ Date of Birth _____
SS# _____
Employer/Address/Phone _____

Secondary Insurance _____
Address _____
City, State, Zip _____
Phone _____
Policy # _____ Group # _____
Insured's Name _____
Address/Phone _____
Sex _____ Date of Birth _____
SS# _____
Employer/Address/Phone _____

Patient's Relationship to Insured: Self Spouse Child Other **Patients relationship to Insured:** Self Spouse Child Other

Emergency Contact Name _____
Address/City/State/Zip _____
Home Phone _____ Bus. Phone _____

Relationship to Patient: Parent Spouse Child Sibling Other

RELEASE OF MEDICAL INFORMATION

List Family members or other persons whom we may release medical information, via verbal or written, to:

Name _____
Relation _____

Name _____
Relation _____

Name _____
Relation _____

Name _____
Relation _____

ACKNOWLEDGEMENT OF PRIVACY NOTICE

Acknowledgement of Review of Notice of Privacy Practice

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient/Guardian

Date Signed

FINANCIAL POLICY

It is the patient's responsibility to provide their most current insurance card(s) and/or referrals at each visit. If you fail to provide your current insurance information, it may be necessary to reschedule your appointment. Payment for any co-pay, deductible or co-insurance is expected at the time of service. If your insurance denies coverage, or does not pay for certain services, you will be financially responsible for these fees. This office will only file claims to insurance companies that we are contracted/participating providers. I understand that I am financially responsible for all charges whether or not paid by said insurance. If you are not covered under any insurance plan, you will be accepted as a "self-pay" and payment in full is due at time of service, unless other arrangements have been made prior to service. (Any payments made via credit card that result in a refund, a 3% charge will be incurred against the refund amount before refund will be issued.) I understand that if I do not make payment for services owed, OSNT will take all necessary and appropriate action to collect any money due on my account, but not limited to the use of collection agencies, or attorneys. I will be responsible for any and all fees associated with these collection efforts. I have read and fully understand the Financial Policy of Orthopedic Specialists of North Texas, LLP.

Signature of Patient/Guardian

Date Signed

ASSIGNMENT OF BENEFITS – ERISA CLAIMS

**Assignment of Benefits
(ERISA Claims – Employer Self Funded Plans)**

I authorize Orthopedic Specialists of North Texas, LLP to be my personal representative, which allows Orthopedic Specialists of North Texas, LLP to: 1) submit any and all appeals when my insurance company denies me benefits to which I am entitled; 2) submit any and all requests for benefit information from my insurance company, and 3) initiate formal complaints to any State or Federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company refused to pay 100% of my benefits within ninety (90) days of any and all appeals or request for information. I also agree that any fines levied against my insurance company will be paid to Orthopedic Specialists of North Texas, LLP for acting as my personal representative.

Signature of Patient/Guardian

ASSIGNMENT OF BENEFITS & AUTHORIZATION FOR RELEASE OF MEDICAL RECORD

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Private Insurance, and any other health plan, to Orthopedic Specialists of North Texas, LLP. 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. I hereby authorize said assignee to release all medical information, including hospital records in the assignee's possession, to my insurance company, attorney or employer, who may have responsibility towards securing payment of my account, including Medicare, where applicable.

Signature of Patient/Guardian

Date Signed

GENERAL CONSENT FOR TREATMENT

I have requested medical services/treatment from Orthopedic Specialists of North Texas, LLP, for myself and/or my dependent. I authorize Orthopedic Specialists of North Texas, LLP to examine and treat myself and/or my dependent as they deem necessary.

Signature of Patient/Guardian

Date Signed

NEW PATIENTS ONLY - How were you referred to our office?

_____ Phone Book

_____ Friend/Relative

_____ Website/Internet

_____ Doctor's Office

_____ Insurance Company

_____ Emergency Room/Hospital

