SPOKANE ORTHOPEDICS
PATIENT INFORMATION

Last Name_____ First Name_____ MI_____

Mailing Address_____City, State, Zip_____

Preferred Phone_____ Age_____ Sex_____ Date of Birth_____ Social Security#_____

Email Address_____

Employer_____Work Phone_____Alternate Phone_____

Primary Care Doctor_____Emergency Contact_____ Phone_____
Relationship_____

How Referred? Dr Friend Family Ads Website Yellow Pages Insurance

GUARANTOR INFORMATION: (if patient is a minor or the person who carries insurance)

Last Name_____ First Name_____MI_____

Address_____(if different than patient)City, State, Zip_____

Preferred Phone _____Sex_____ Date of Birth_____ Social Security #_____

Employer_____Relationship to patient_____

INSURANCE INFORMATION:

1. Primary Insurance_____

Name of Subscriber_____Birthdate_____ Employer_____

2. Secondary Insurance_____

Name of Subscriber_____Birthdate_____ Employer_____

Reason for Visit_____

Were you injured at Work?_____ Auto?_____ Home?_____ Date of Injury or Onset (Required)_____

Have you been treated by other Doctors for this Problem?_____ Who and When_____

Do you have or do you expect to have attorneys involved for this problem?_____

The Federal Government, including the Department of Health and Human Services are requesting medical practices to ask the following information to better meet the needs of our patients. If the choices are not accurate, please circle "other", or if you do NOT wish to participate in this study, please circle the "decline" box.

What is your Primary Language? English Spanish Russian Other Decline

What is your Race? American Indian or Alaskan Native Asian Black or African American
Native Hawaiian, Pacific Islander White Hispanic or Latino Other Decline

What is your Ethnicity? Not Hispanic or Latino Hispanic or Latino Decline

220 E. Rowan Suite 100 Spokane WA 99207 Phone: 509-489-2851 Fax: 509-484-0103

SPOKANE ORTHOPEDICS

My Signature below affirms that I have received or denied receipt of the Spokane Orthopedics Patient Rights and Privacy Policy, also known as the HIPAA policy, which explains my rights related to my Health Care Information. HIPPA Policy located on the back of Spokane Orthopedics welcome letter.

I authorize Spokane Orthopedics to bill and collect payment from my insurance carrier and release any information necessary for that purpose. I have given complete and accurate information and accept responsibility for payment if my insurance carrier denies coverage for services or products provided to me.

PATIENT SIGNATURE_____ DATE_____

MEDICARE SIGNATURE RELEASE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the provider listed, for any services furnished me by the listed provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT SIGNATURE_____ DATE_____

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