

FIRST STATE ORTHOPAEDICS



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|---|--|-------------------------------------|------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Dr. Axe | <input type="checkbox"/> Dr. Bodenstab | <input type="checkbox"/> Dr. Brady | <input type="checkbox"/> Dr. Crain | <input type="checkbox"/> Dr. Ginsberg | <input type="checkbox"/> Dr. Handling |
| <input type="checkbox"/> Dr. Hershey | <input type="checkbox"/> Dr. Johnson | <input type="checkbox"/> Dr. Kahlon | <input type="checkbox"/> Dr. Katz | <input type="checkbox"/> Dr. Leitman | <input type="checkbox"/> Dr. Moran |
| <input type="checkbox"/> Dr. Pushkarewicz | <input type="checkbox"/> Dr. Raisis | <input type="checkbox"/> Dr. Rudin | <input type="checkbox"/> Dr. Sowa | <input type="checkbox"/> Dr. Steele | <input type="checkbox"/> Dr. Straight |

PATIENT INFORMATION

Name _____ (LAST) (FIRST) (MI)	Date of birth _____ <input type="checkbox"/> Male
Address _____	Age _____ <input type="checkbox"/> Female
Development _____	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
City/State/Zip _____	Relationship to responsible person _____
Home phone () _____ Cell () _____	Social Security No. _____
Family Doctor _____ Phone () _____	E-Mail: _____
Referring Dr. _____ Phone () _____	Occupation _____
How did you hear about us? _____	Employed by _____
Referring Attorney Name _____	Business Phone () _____

PERSON RESPONSIBLE FOR PAYMENT (IF NOT PATIENT)

Name _____ (LAST) (FIRST) (MI)	Social Security No. _____
Address _____	Relationship to Patient _____
Development _____	Occupation _____
City/State/Zip _____	Employed by _____
Home phone () _____	Business Phone () _____

INSURANCE INFORMATION

PRIMARY	
Subscriber's Name _____ (LAST) (FIRST) (MI)	Patient's I.D. No. _____
Insurance Co. Name _____	Group/Account No. _____
Insurance Co. Address _____	Relationship to Patient _____
City/State/Zip _____	Date of birth _____
	Social Security No. _____

SECONDARY	
Subscriber's Name _____ (LAST) (FIRST) (MI)	Patient's I.D. No. _____
Insurance Co. Name _____	Group/Account No. _____
Insurance Co. Address _____	Relationship to Patient _____
City/State/Zip _____	Date of birth _____
	Social Security No. _____

Box **Auto Accident** **Work Injury** **Personal Injury**

Insurance Co. Name _____	Date of Injury _____
Insurance Co. Address _____	State in which injury occurred: _____
City/State/Zip _____	Claim Number _____
Insurance Co. Phone () _____	(Complete the following if accidental injury)
Name of Adjuster _____	Where Accident Occurred: _____
Name of Attorney _____ Phone () _____	How Accident Occurred: _____

FIRST STATE ORTHOPAEDICS

WHO MAY WE TALK TO ABOUT YOUR CARE?

You may communicate with the following individuals about my care:

Name	Relationship	Phone Number
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FIRST STATE SURGERY CENTER / SPINE CARE DELAWARE

The First State Surgery Center and Spine Care Delaware are Ambulatory Surgery Centers owned and operated by Physicians of First State Orthopaedics. While our outpatient surgery centers are an appropriate site for your surgical procedure, there are other facilities in the area where such procedures could also be performed. There will be a separate facility fee for surgeries performed at First State Surgery Center or Spine Care Delaware as there would be from any other facility.

FIRST ASSISTANT AT SURGERY

First State Orthopaedics, P.A. employs board certified physician assistants who are trained to perform the duties of a first assistant at surgery and to assist in the office. Our billing to your insurance carrier may include a fee for the physician assistant.

FINANCIAL RESPONSIBILITY STATEMENT / INSURANCE ASSIGNMENT

I accept responsibility to insure that payment is made for all services rendered on my behalf. I understand that my insurance policy is a contract between me and my insurance company and that I am responsible to First State Orthopaedics, P.A., for all fee balances determined to be patient responsibility. I acknowledge that it is also my responsibility to obtain a referral from my PCP if required or I will be responsible for payment of FSO fees.

FSO reserves the right to charge a cancellation fee for missed or cancelled appointments without 24 hours advanced notice

I hereby authorize and direct payment to First State Orthopaedics, P.A., for surgical and / or medical benefits, if any otherwise payable to me under the terms of any applicable insurance. I authorize the release of any medical information necessary to process claims. I hereby authorize photocopies of this form to be as valid as the original.

First State Orthopaedics, P.A., is hereby authorized to take any legal action which may be necessary either in law or in equity in my name against any insurance company for any and all fee balances, and I covenant and agree to cooperate fully with First State Orthopaedics, P.A., in the presentation of such claims and to furnish all papers and documents necessary in such proceedings and to attend court and testify if First State Orthopaedics, P.A., deems such to be necessary.

In the event of default on any payment due to First State Orthopaedics, P.A., which are my responsibility, I agree to pay a cost of collection including attorney fees. Balances not paid within 90 days are subject to collection procedures and a collection fee.

I AGREE TO THE ABOVE CONDITIONS

If the patient is a minor, the parent or legal guardian must sign

Signature of patient, parent or legal guardian

Date

MEDICARE SIGNATURE ON FILE

" I request that payment of authorized Medicare benefits be made on my behalf to First State Orthopaedics, P.A., for any services furnished me by that physician's). I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS), which oversees the Medicare program, and its agents any information needed to determine these benefits payable for related services."

Signed: Medicare Beneficiary

Date

**THE PATIENT / GUARANTOR IS RESPONSIBLE FOR
ALL ACCOUNT BALANCES AFTER INSURANCE HAS PAID**