

**Doctor**

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Patient ID# \_\_\_\_\_ Sex [ ]M [ ]F  
Address: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Drivers License: \_\_\_\_\_  
Phone 1: \_\_\_\_\_ [ ]Home [ ]Work [ ]Other Social Security #: \_\_\_\_\_  
Phone 2: \_\_\_\_\_ [ ]Home [ ]Work [ ]Other Marital Status: [ ]Married [ ]Single [ ]Divorced  
Referred Physician: \_\_\_\_\_  
Primary Physician: \_\_\_\_\_

**Patient Employment Information**

[ ]Employed [ ]Retired [ ]Unemployed [ ]Other  
Employer's Name \_\_\_\_\_  
Employer's Phone \_\_\_\_\_  
Occupation: \_\_\_\_\_

**EMERGENCY CONTACTS**

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____

**RESPONSIBLE PARTY**(If patient is under 18 years of age)

Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
SSN: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PRIMARY INSURANCE**

Insurance Company Name: \_\_\_\_\_  
ID#: \_\_\_\_\_  
Group Policy#: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_  
Subscriber's Phone#: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Subscriber's Employer: \_\_\_\_\_  
Subscriber's SS#: \_\_\_\_\_  
Subscribers Date of Birth: \_\_\_\_\_

**SECONDARY INSURANCE**

Insurance Company Name: \_\_\_\_\_  
ID#: \_\_\_\_\_  
Group Policy#: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_  
Subscriber's Phone: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Subscriber's Employer: \_\_\_\_\_  
Subscriber's SS#: \_\_\_\_\_  
Subscriber's Date of Birth: \_\_\_\_\_

**WORK RELATED INJURY**

Only applicable if injury is related to work or auto accident

Insurance Carrier Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
Claim Number: \_\_\_\_\_ Date of Injury: \_\_\_\_\_  
Employer at Time of Injury: \_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT  
(PLEASE READ AND SIGN)**

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. **I understand that I am responsible for any amount not paid for by my insurance.**

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

## OFFICE POLICIES & FINANCIAL AGREEMENT

Welcome to Sports Medicine Oregon. We are committed to providing you with the best possible services and we also want you to understand our policies regarding professional fees, your financial responsibility, and our billing practices. Please feel free to ask the office staff or business office for clarification should you have any questions. A copy of this signed financial agreement will be given to you for your records.

### **PROFESSIONAL FEES**

Our fee schedule is based on prevailing standards in the community and in compliance with Medicare.

### **WORKERS COMPENSATION/MOTOR VEHICLE ACCIDENT**

Patients, who are being seen for a Workers ' Compensation claim or a motor vehicle accident, will be responsible for any services that are denied. Your claim with the insurance company does not guarantee payment.

### **REFERRALS**

The patient or legal guardian (of a minor) is responsible for obtaining any referral required by their primary care physician to a specialty physician as outlined in their agreement with their insurance company. This may include X-ray, diagnostic procedures, physical therapy, medication, surgical procedures and any treatment done in addition to the office visits.

### **FINANCIAL AGREEMENT**

Many people believe when they use their health insurance it is the insurance company that owes the doctor for their services. This is not the case. The health insurance contract is **between you and your insurance company**. Therefore, you are responsible for payment of all fees regardless of any insurance coverage. As a courtesy to our patients we will bill all insurance companies if orthopedic services are covered. If you are using your health insurance, you must supply us with complete information about your coverage and a copy of your health insurance card. If you belong to a managed healthcare plan, **all co-payments are due at the time of service**. Most health insurance plans do not cover 100% of the cost for medical treatment. If your insurance has not paid for covered services within 60 days of the service, you will need to make full payment to this office and be reimbursed when the insurance pays. Prior to elective surgery, Sports Medicine Oregon will provide an estimate of "out of pocket" physician charges, **a deposit will be requested and payments scheduled on your date of surgery**.

All non-covered services (i.e.. supplies, not eligible at time of service) that are not a covered benefit per the contract with your insurance company, is due upon receipt of your billing statement or payable according to an agreement that you have made with the business office. You will receive a monthly statement showing any balance due.

Patients who are not insured are expected to pay fees in full at the time of service unless other arrangements have been made with the business office. You will receive a monthly statement showing any balance due. **All checks returned to our office for non sufficient funds will incur a \$30.00 charge for the processing fee.**

### **Please sign and return this form to the receptionist.**

*I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If I am using my health insurance benefits, I hereby assign my insurance to Sports Medicine Oregon and I authorize Sports Medicine Oregon and their staff to provide to my insurance company any information regarding myself or my minor child that is required or necessary for the submission of a claim for services provided by them. I understand I have access to any and all information provided. I agree to the above terms and conditions and I acknowledge that I have received a copy of these office policies and financial agreement.*

\_\_\_\_\_  
Please Print Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Sign Here