MIDSOUTH ORTHOPAEDIC REHABILITATION, LLC
Child Form

DATE:_____ **CHART #** _____

Patient Name_____ Date of Birth:_____ Age:_____

Address of Patient:_____City_____State_____Zip_____ Male__Female__

Social Security #:_____ Home Phone:(____)_____ Cell Phone(_____)_____

Email Address:_____School Attending:_____

Referred by: _____ Phone: _____

Family Physician: _____ Phone: _____

Part(s) of Body here for: _____ Date of first symptom(s) this episode_____

Were you injured? Yes No If so, how? _____

Emergency Contact:_____ Relationship:_____ Phone:(____)_____
(not living at same address as patient)

What was the greatest factor in you choosing our clinic: Physician referred, Family/friend referred, Insurance provider list Yellow pages Other, _____

Mark any of our advertisements you have seen: Website, Business Networking International (BNI), Community Event, Yellow pages, Other, _____

LEGAL GUARDIAN INFORMATION

(If under 18 years of age)

Mother's Name:_____DOB_____Are you a legal guardian? Yes No
Employer's Name_____Occupation:_____
Employer's Address_____ City_____State_____Zip_____
Work#_____Home#_____Cell#_____Soc Sec#_____

Father's Name:_____DOB_____Are you a legal guardian? Yes No
Employer's Name_____Occupation:_____
Employer's Address_____ City_____State_____Zip_____
Work#_____Home#_____Cell#_____Soc Sec#_____

	PRIMARY:	**SECONDARY:**
Insurance Company:	(**1**)_____	(**2**)_____
Subscriber's:	Date of Birth:_____ Male/Female	Date of Birth:_____ Male/Female
Subscriber's	Soc Sec#:_____	Soc Sec#_____
Name of Subscriber:	_____	_____

FINANCIAL RESPONSIBILITY

WE WILL FILE YOUR PRIVATE HEALTH INSURANCE AND YOU WILL RECEIVE EXPLANATION OF BENEFITS. AT THE TIME OF EACH VISIT, YOU ARE RESPONSIBLE FOR PAYING CO-PAYS, DEDUCTIBLES, AND BALANCE DUE AFTER FILING INSURANCE. YOU ARE RESPONSIBLE FOR PROMPTLY RESPONDING TO ALL INSURANCE INQUIRES.

I ACCEPT PERSONAL RESPONSIBILITY FOR PAYMENT OF CHARGES FOR SERVICES RENDERED TO ME. I AUTHORIZE BILLING AND PAYMENTS OF MEDICAL INSURANCE BENEFITS TO MIDSOUTH ORTHOPAEDIC REHABILITATION. I UNDERSTAND THAT A PROFIT IS COLLECTED FROM ANY DME OR SUPPLY I PURHCASE FROM THIS OFFICE. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR A $50 CHARGE FOR FAILURE TO GIVE 24 HOURS NOTICE OF CANCELLATION/RESCHEDULING. IF MY ACCOUNT HAS TO BE ASSIGNED TO AN ATTORNEY FOR COLLECTION OF SUIT, I WILL BE RESPONSIBLE FOR LEGAL FEES AND COLLECTION COST, WHICH MAY BE AS MUCH AS 40% OF THE ORIGINAL AMOUNT. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS.

I HAVE RECEIVED A COPY OF THE HIPAA/PRIVACY ACT.
DATE: _____ SIGNATURE OF PATIENT/INSURED:_____