MIDSOUTH ORTHOPAEDIC REHABILITATION, LLC

DATE:_____ **CHART # _____**

Mr., Mrs., Miss, Ms._____ Date of Birth:_____ Age:_____

Address:_____ Single Married Employed Student Male Female

City:_____State:_____Zip:_____ Other

Email:_____ Home Phone:(____)_____

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

Employer or School Attending:_____ Job Title:_____

Time related to Activities required with work: Sit____%; Stand____%; Walk____%; Lift < 10 lbs ____%; Lift > 10lbs___% Other___%(specify)

Referred by: _____ Phone: _____

Family Physician: _____ Phone: _____

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

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

Work Related: Yes No ; **Auto Accident:** Yes No ; **Law Suit Pending**: Yes No ; **Permanently Disabled** Yes No

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

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

EMERGENCY INFORMATION :

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

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

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 OR NOT SHOWING UP FOR MY SCHEDULED APPOINTMENT AND $25 FOR 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 UNDERSTAND THAT MY ADDRESS, PHONE NUMBERS AND EMAIL WILL BE USED FOR THE FOLLOWING PURPOSES BUT NOT LIMITED TO FOR CONTACTING ME REGARDING MY APPOINTMENTS, BILLING AND BALANCE ISSUES AND TO UPDATE ME REGARDING INFORMATION REGARDING MIDSOUTH ORTHOPAEDIC REHAB (MOR). MOR WILL PROTECT MY INFORMATION AND NOT KNOWINGLY DISPERSE IT TO ANY OTHER INDIVIDUAL OR ENTITY .

I HAVE RECEIVED A COPY OF THE HIPAA/PRIVACY ACT.

DATE: _____ SIGNATURE OF PATIENT/INSURED:_____

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