



Date \_\_\_\_\_

### Demographics

Name \_\_\_\_\_ SS# \_\_\_\_\_  
 Address \_\_\_\_\_ City/St/Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Email \_\_\_\_\_  
 DOB \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
 Referring Doctor \_\_\_\_\_ Phone \_\_\_\_\_  
 Primary Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ SS# \_\_\_\_\_  
 Address \_\_\_\_\_ City/St/Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 DOB \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Insurance Co \_\_\_\_\_  
 Address \_\_\_\_\_ City/St/Zip \_\_\_\_\_  
 Contact \_\_\_\_\_ Phone \_\_\_\_\_  
 Claim # \_\_\_\_\_ Date of Injury \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Address \_\_\_\_\_ City/St/Zip \_\_\_\_\_  
 Phone \_\_\_\_\_

Primary Insurance \_\_\_\_\_  
 ID# \_\_\_\_\_ Group # \_\_\_\_\_  
 Ins Holder \_\_\_\_\_ DOB \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_ Sex \_\_\_\_\_ SS# \_\_\_\_\_

Secondary Insurance \_\_\_\_\_  
 ID# \_\_\_\_\_ Group # \_\_\_\_\_  
 Ins Holder \_\_\_\_\_ DOB \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_ Sex \_\_\_\_\_ SS# \_\_\_\_\_

I authorize the release of any medical records necessary to process any claims I may incur and assign to Suburban Orthopaedics, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy(ies) with the above named insurance company(ies) for services rendered to me. I agree that I am financially responsible for incurred charges resulting from my medical care from Suburban Orthopaedics, and its physicians

X \_\_\_\_\_ Date \_\_\_\_\_

Patient or Authorized Person's Guardian

**Patient**  
**Guardian**  
**Work Comp**  
**Insurance**



## Acknowledgement of Receipt of Suburban Orthopaedics Financial Policy Summary

Thank you for choosing us as your care provider. We are committed to the successful treatment of your medical condition. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please call our billing department if you have any questions. They may be reached at 630-372-1100. You authorize the release of any medical records necessary to process any claims I may incur and assign to Suburban Orthopaedics, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy(ies) with the above named insurance company(ies) for services rendered to me. The patient, or legal guardian, is always responsible for payment. In consideration of services to be rendered, you, as the undersigned patient or guarantor for patient, agree to pay Suburban Orthopaedics for all services and supplies provided to you (or the patient, as applicable) at the established rates, including any deductibles, co-payment or other charges, as permitted by third party payers. By signing this financial policy summary, you accept responsibility for any costs, including late fees, collection costs, returned checks and attorney's fees incurred by Suburban Orthopaedics in the collection of these charges for examination, diagnosis and treatment received. Furthermore, you certify that the information given by you for purposes of payment is, to the best of your knowledge, complete and accurate.

Additionally:

- ❖ Full payment is due at time of service for self-pay patients or if insurance information (and copy of insurance card) is NOT provided.
- ❖ We accept cash, checks, Visa/MasterCard/Discover/AMEX.
- ❖ All patients must complete our "patient registration form" and other forms provided at the time of registration.
- ❖ For cases in which we bill insurance directly, we MUST HAVE A COPY OF THE CURRENT INSURANCE ID CARD.
- ❖ Please notify us immediately of any changes in your insurance information or coverage.
- ❖ At least 48 hours notice is required for copies of medical records or x-rays and there may be a nominal fee.
- ❖ You are ultimately responsible for payment of all services.

### Medicare

We accept Medicare assignment. As a Medicare patient, you are responsible only for the difference between Medicare's approved charge and the amount Medicare pays, your deductible and charges for any service not covered by Medicare. If you have supplemental insurance, we will bill it directly for you. You will receive a bill after your insurance has paid.

**If you are in a skilled medical nursing facility (permanently or temporarily residing in a nursing home or rehabilitation center):**

Facility Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_

### HMO/PPO

**ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. IF YOU DO NOT KNOW YOUR CO-PAY YOU MAY USE OUR PHONE TO FIND OUT.** We are a member of most, but not all, insurance plans. You are responsible for verifying that we are an in-network provider under your plan. If you are an HMO member, you will not be billed as long as you have obtained the necessary referrals. All patients will be responsible for their co-payments, co-insurance and deductibles as applicable and as long as they have verified with their insurance company that our physician is in their plan.

### Workers' Compensation

If you are here as a result of a work-related injury, we require information regarding both health insurance and your Workers' Compensation insurance. At the time of your appointment, you must provide us with  your employer's name and a contact there with phone number  your health insurance card  (if possible) Workers' Compensation Case Number. If you do not provide this information you will be expected to pay at the appointment time. Regardless of disputes between your health insurer and your employer, you are responsible for the payment of your healthcare bills.

### Insurance Disputes

If there is a dispute regarding the payment of your insurance claim, Suburban Orthopaedics has the right to bill you prior to the resolution of that dispute and to anticipate payment from you.

### Auto and Other Accident Claims

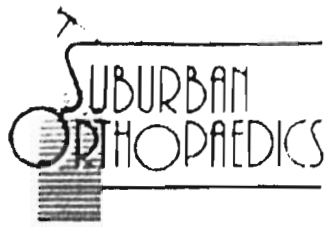
If you are here as a result of an accident claim we may require you to be a self-pay patient or we may require information regarding health insurance, accident/auto insurance, the name, address and phone number of your attorney and identifying information relating to your claim. Suburban Orthopaedics may, at its discretion, and in lieu of billing your insurance, place a "Physician's Lien" on your claim/case for payment. By signing the form, below, you are indicating that you have read this paragraph, and that you agree that Suburban Orthopaedics may at its sole discretion, use this method of reimbursement for treatment rendered, without objection from you or from your attorneys.

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_

Date: \_\_\_\_\_



**HIPPA / RELEASE OF INFORMATION FORM**

**ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES**

I acknowledge that I received, reviewed or was offered the HIPPA of Privacy Practices of Suburban Orthopaedics.

Initials: \_\_\_\_\_

**DEMOGRAPHIC & MEDICAL HISTORY INFORMATION**

I verify that all the demographic and medical history information is current and accurate to my knowledge.

Initials: \_\_\_\_\_

**EMERGENCY CONTACT NAME**

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**INFORMATION RELEASE**

I authorize my private health information to be discussed with the following people, either over the phone or in the office:

Name	Relationship
_____	_____
_____	_____
_____	_____

I authorize private health information to be left on a voicemail/answering machine at the following numbers:

Phone Number	Location (home/work/cell)
_____	_____
_____	_____
_____	_____

I verify that all the demographic and medical history information I have reviewed is current and correct. I have received all information regarding Suburban Orthopaedics policies and practices.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**PARENT/GUARDIAN AUTHORIZATION AND CONSENT  
FOR MEDICAL TREATMENT OF A MINOR**

**Child/Minor**

Full Legal, Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

**Parent(s)/Legal Guardians(s) #1:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Pager: \_\_\_\_\_  
Email: \_\_\_\_\_  
Additional Contact Information: \_\_\_\_\_

**Parent(s)/Legal Guardians(s) #2:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Pager: \_\_\_\_\_  
Email: \_\_\_\_\_  
Additional Contact Information: \_\_\_\_\_

**AUTHORIZATION AND CONSENT OF PARTENT(S) OR LEGAL GUARDUAN(S)**

I, the undersigned, do hereby affirm and represent that I am the Parent/Legal Guardian of the aforementioned minor child.

On behalf of the minor child, I hereby consent and authorize **Suburban Orthopaedics** to provide reasonable and necessary medical treatment to the minor child, including necessary examinations, x-rays or other reasonable diagnostic services, and to provide follow-up services as may be required following the examination and treatment for an initial medical conditions described as follows:

**Description of Condition/Injury**

By executing this Consent and Authorization, the Parent/Legal Guardian expressly authorizes **Suburban Orthopaedics** to provide subsequent reasonable and necessary medical care to the minor child without the Parent/Guardian being present on the dates for subsequent visits where the subsequent treatment is directly related to the above described medical condition. If the patient is seen as a result of a referral from a school Athletic Trainer, the **Suburban Orthopaedics** is authorized to discuss the minor's medical care with the Athletic Trainer.

Signed this \_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

\_\_\_\_\_  
Parent/Legal Guardian



## Medical History

1. Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Sex: Male Female Height: \_\_\_\_\_  
Referring Doctor: \_\_\_\_\_ Dominant Hand: Right Left Weight: \_\_\_\_\_  
Reason for your Visit (body part): \_\_\_\_\_

Is the injury work related? Yes No Have you filed a claim? Yes No

2. Have you had any of the following during the past week?

Fever or Chills	Yes	No
Blurred Vision	Yes	No
Shortness of Breath	Yes	No
Chest Pain	Yes	No
Sore Throat	Yes	No
Nausea	Yes	No
Painful Urination	Yes	No
Rashes	Yes	No
Headaches	Yes	No

3. List any medication(s) you are allergic to: \_\_\_\_\_

4. List any medication(s) you are currently taking: \_\_\_\_\_

5. List any previous surgeries and the date which they took place: \_\_\_\_\_

6. Do any of the following medical conditions run in your family?

	Yes	No	List your Relation
Diabetes	Yes	No	_____
Heart Attack	Yes	No	_____
Stroke	Yes	No	_____
Anesthesia Problems	Yes	No	_____

7. List any medical conditions: \_\_\_\_\_

8. Do you use tobacco? Yes No

9. Do you use alcohol? Yes No