



Today's Date: _____

PATIENT INFORMATION

Patient Name _____ Sex _____ Marital Status _____
Date of Birth _____ Age _____ Social Security Number _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work _____ Cell _____
Employer _____ Occupation _____
Employer's Address _____

Spouse's Name _____ Social Security Number _____
Employer _____ Work Phone _____

REASON FOR APPOINTMENT? _____

Is this injury related to: (Circle one) Work Auto Accident Sports Other _____

Date symptoms began or accident happened? _____

Have you seen anyone else for this injury/accident? Y N If yes, who did you see _____

****If this is a work related injury, please fill out work comp information instead of insurance information listed below.**

INSURANCE INFORMATION

Primary Insurance _____ Cardholder _____ Relationship to Patient _____ Date of Birth _____ Social Security Number _____	Secondary Insurance _____ Cardholder _____ Relationship to Patient _____ Date of Birth _____ Social Security Number _____
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WORK COMP INFORMATION

Have you reported this injury at work? Yes _____ No _____
How did the injury occur? _____

Contact Person for Employer _____ Phone _____
Work Comp Insurance Company _____
Adjuster _____ Phone _____
Claim Number _____

IF PATIENT IS A MINOR OR STUDENT PLEASE COMPLETE THIS SECTION

Father's Name _____ Mother's Name _____
Address _____ Address _____
Phone _____ Phone _____
Employer _____ Employer _____
Work Phone _____ Work Phone _____
Social Security Number _____ Social Security Number _____
Date of Birth _____ Date of Birth _____

CONTACT INFORMATION

Emergency contact person _____ Relationship _____
Home Phone _____ Cell Phone _____

Who may we release medical information to?

1. _____ Phone Number _____
Relationship _____
2. _____ Phone Number _____
Relationship _____
3. _____ Phone Number _____
Relationship _____

May we leave medical information on an answering machine or voice mail? Y N Work
Home Cell phone

How did you hear about us?

Referring Physician _____ Phone Number _____
Primary Care Physician _____ Phone Number _____

Patient Name _____ Date of Birth _____ Primary Care Physician _____

MEDICATIONS

Medication/Vitamin/Supplement/Herbals	Dose and Frequency	Reason for taking	Medication/ Vitamin/ Supplement	Dose and Frequency	Reason for taking

HEALTH HISTORY (circle all that apply)

- | | | | |
|------------------------|-------------------------|---------------------|---------------------|
| Acid reflux/heartburn | Emphysema | High cholesterol | Shortness of breath |
| Asthma | Eye Problems | Irregular Heartbeat | Sinus Problems |
| AIDS/HIV | Foot/leg cramping | Kidney problems | Sleep apnea |
| Anemia | Gout | Lung disorder | Stroke |
| Arthritis | Heart Attack | Nervous/anxiety | Thyroid disorders |
| Artificial Heart Valve | Heart Disease | Osteoporosis | Tuberculosis |
| Bleeding disorders | Heart Murmur | Pacemaker | Ulcers |
| Cancer | Head Aches | Psychiatric care | None |
| Chest Pain | Hearing problems | Radiation/chemo | |
| Diabetes | Hepatitis/liver disease | Rheumatic fever | |
| DVT/blood clots | High blood pressure | Seizures | |

ALLERGIES (circle all that apply)

- | | | | |
|----------------------|-----------------|--------------|--------------------|
| Adhesive tape | Morphine | Novocain | Penicillin |
| Latex | Shrimp, Iodine, | Other: _____ | No known allergies |
| Sulfa Drugs | Merthiolate | | |
| Advil, Aleve, Motrin | Aspirin | Codeine | |

SURGICAL HISTORY

Surgery	Date	Surgery	Date

FAMILY HEALTH HISTORY (circle all that apply)

- Heart disease High blood pressure Diabetes Cancer Stroke Bleeding disorder

SOCIAL HISTORY

Smoking _____ Packs daily _____ Started _____ Stopped _____
 Alcohol _____ How often? _____ How much? _____
 Exercise? _____ What type? _____ How often? _____

Hand dominance? (please circle) Right handed Left handed Ambidextrous

Patient Signature _____ Date _____

Doctor _____ Date _____

For office use only

Date				
Height				
Weight				

FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. Our staff will ask you to verify your billing information at each and every visit. Current information is essential in order for us to contact you regarding your treatment and for obtaining timely payment from your insurance company.

FORMS OF PAYMENT: We accept Cash, Checks, Visa, MasterCard, American Express and Discover.

TREATMENT OF MINOR CHILDREN: A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account.

REFERRALS: If your insurance plan requires a referral from a primary care physician it is YOUR responsibility to obtain the referral prior to your appointment and to have it with you at the time of the appointment. If you do not have your referral, **you may have to reschedule your appointment.**

SELF-PAY PATIENTS: Payment in full is required at the time of service for patients that do not have insurance coverage or for those patients that do not present their insurance card at time of appointment.

PATIENT RESPONSIBILITY: Patients are required to pay all co-pay and deductible amounts at the time of service. Patients are also responsible for any and all remaining balances due after insurance. ROSM billing staff will make every effort to bill a patient's insurance and will ensure that claims are promptly and correctly processed. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply in a timely manner with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim.

PAST DUE BALANCES: If you have any outstanding balances and you have been billed more than once without payment, you may be required to reschedule your appointment. A past due balance is any amount owed from a prior visit where insurance is not pending, the account has been sent to collections or an insurance payment has not been received by Rezin Orthopedics and Sports Medicine, S.C. within 60 days. Balances on accounts with payment plans where payments conform to the plan are not considered past due balances.

For accounts turned over to an outside collection agency, it is understood and agreed that the patient will be responsible for a collection fee of 29% of their unpaid balance which is in addition to the unpaid balance being submitted to the collection agency. This fee covers, unless prohibited by law, all reasonable attorney fees, filing fees, court costs, collection agency costs, service fees and other related collection costs or contingencies. It is also understood that by signing this form permission is given to any agents or assignees of said collection agency to contact the patient and/or responsible party at any telephone number listed on the patient registration form.

PAYMENT PLANS: Patients are encouraged to pay outstanding balances in full; however payment plans may be available.

MEDICARE: Patient will be responsible for their yearly Medicare deductible (if not met) and the 20% coinsurance in those cases where patient does not have a Medicare secondary insurance. The Billing Office, as a courtesy to the customer, will bill insurance secondary to Medicare. If secondary insurance payments are not received within 60 days, the patient will be requested to pay the unpaid coinsurance in full.

IDPA: Patients must present their current Illinois Department of Public Aid medical card upon check-in for each appointment. Payment of any applicable IDPA co-pay must be paid by the patient or their responsible party at each scheduled appointment.

PPO- PLANS (currently contracted with ROSM): When services are covered by the plan, patient will be responsible for any applicable co-pay, deductible, coinsurance and any amounts deemed "patient share" by their carrier. Patients must pay their co-pay at each scheduled appointment. Patients will be responsible for all services excluded from their plan. Payment for services is due at the time services are rendered.

OUT OF NETWORK PLANS: ROSM's Billing Office will bill non-contracted medical plans as a courtesy to the patient, but patient is ultimately responsible for all charges. It is not ROSM's policy to accept usual & customary adjustments from non-contracted plans and patient will be balanced billed for balances remaining after their insurance company pays.

SECONDARY & TERTIARY INSURANCES: The Billing Office, as a courtesy to the customer, will bill a patient's secondary insurance. If secondary insurance payments are not received within 60 days, the patient will be requested to pay the unpaid amount in full. If payment is eventually received from the patient's secondary insurance, a refund of the portion of the overpayment paid by the patient will be refunded back to the patient. ROSM does not bill tertiary insurance.

WORKERS COMPENSATION: The Work Comp Coordinator will attempt to obtain approval for patients requesting an appointment when injuries are due to a work related incident prior to scheduling an appointment. If prior approval is not obtained, the patient will be responsible for all charges for services rendered.

THIRD PARTY INSURANCE: ROSM will not accept third party auto, home owners or commercial liability insurance unless your primary insurance is Medicare or IL Public Aid. The patient will be responsible for all charges.

LIENS: ROSM will not accept liens in lieu of payment. If insurance companies cease to pay, any and all out-standing amounts will be balanced billed to the patient and will become their responsibility to pay.

FINANCIAL ARRANGEMENTS FOR SURGERY: If your physician recommends surgery, you will be contacted by a Surgery Scheduling Coordinator to discuss any paperwork, arrange any needed tests prior to surgery and complete all pre-certification/ authorization that may be needed. The Surgery Scheduling Coordinator may also request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount.

FRACTURE CARE: Some insurance companies require that fracture care billing be done on a "global" basis. This means that for a pre-determined amount of time all professional services related to the fracture care are included within an initial fee paid by the insurance company. X-Rays and casting/splinting, along with related supplies are not included within the global fee and are billed separately. Please note, that injections, joint aspirations and fracture care are all procedures listed as "surgical" for billing purposes by insurance companies. Though these services may be provided in the office or emergency room, they are generally listed on your explanation of benefits or bill as "surgical".

FORMS (DISABILITY, FMLA ETC): There is a charge for completing any form that is not directly related to reimbursement of medical services. For compliance purposes, the patient information portion of the form must be completed, signed and payment must be received before ROSM will complete the remaining portion of the form.

MISSED OR CANCELLED APPOINTMENTS: You may be charged for a missed or cancelled appointment if you do not notify us at least 24 hours prior to your schedule appointment time.

RELEASE OF INFORMATION and AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I authorize Rezin Orthopedics to release to my insurance company or its representatives, information including the diagnosis and the records of any treatment or examination rendered to me that may be required to process my claim for benefits. I authorize and request that my insurance company pay directly to the above named practice the amount due in my pending claim for medical treatment or services, by reason of such treatment or services rendered to me. This assignment will remain in effect until revoked by me in writing.

I understand and agree that, regardless of my insurance policy, I am responsible for the entire balance on my account, for all professional services provided to the patient (or myself). I have read all the information contained in the Financial Policy. I certify that, to the best of my knowledge, this information completed on the Patient Information form is correct and true. I will notify this office in case of any changes to my health or any of the attached information.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read and choose not to) and understood the Notice.

Date: _____

Signature: _____

Patient Name (Print): _____

Patient or Authorized Representative (if applicable) Signature