Patient Registration: Demographic Information

Account Number: _____

Demographics

First Name: _____ **Last Name:** _____ **Middle Initial:**_____

Address: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:**_____

Date of Birth: _____ **Social Security:** _____-_____-_____

Email Address: _____ **Preferred Contact:** □ Phone □ Text □ E-mail

Sex: □ Male □ Female **Marital Status:** □ Single □ Married □ Separated □ Divorced □ Widowed

Ethnicity: □ Hispanic □ Non-Hispanic □ Other **Preferred Language:** □ English □ Spanish □ _____

Race: □ Caucasian □ African American □ Asian □ Hawaiian □ Pacific Islander □ Other

Additional Information

Primary Care Physician: _____ **Referring Physician:** _____

How Did You Hear About Us:

□ Friends and Family □ Internet Search □ Facebook □ Youtube □ Artificial Intelligence □ Insurance

□ Physician Referral □ Emergency Room/Urgent Care □ Physical Therapy Referral

Pharmacy Name: _____ **Pharmacy Type:** □ Retail □ Mail Order

Pharmacy Phone Number: _____ **Pharmacy Fax:** _____

Pharmacy Address: _____

Employment: □ Full-Time □ Part-Time □ Retired □ Unemployed □ Disabled □ Student

Please provide an EMERGENCY CONTACT:

Name: _____ **Relationship to Patient:** _____

Home Phone: _____ **Cell Phone:** _____

Orthopedic Institute of North Texas

Patient Registration: Insurance Information

Is your visit today in regards to an injury at work? □ **Yes** | □ **No**

IF YES, PLEASE NOTIFY FRONT DESK. THERE ARE ADDITIONAL FORMS THAT ARE REQUIRED.

Medical Insurance

Primary Insurance Carrier: _____ **ID#:** _____ **Group#:**_____

Secondary Insurance Carrier: _____ **ID#:** _____ **Group#:**_____

Subscriber Info: □ Patient(Self) □ Other (if other, please complete fields below

First Name: _____ **Last Name:** _____ **DOB:**_____/___/_____

Address: _____

Home Phone: _____ **Cell Phone:** _____ **Relationship to Patient:**_____

Workers Compensation Insurance

Insurance Carrier: _____ **Policy Number:** _____

Date of Injury: _____/___/_____ **Claim Number:** _____

Full Claim Address: _____

Adjuster/Case Manager Information:

Name: _____ **Phone:** _____ **Fax:** _____

Attorney Information (If Applicable):

Name: _____ **Phone:** _____ **Fax:** _____

Financial Policy

Thank you for choosing the Orthopedic Institute of North Texas as your healthcare provider. The healthcare industry is rapidly evolving and with the constant change in insurance policies and the growing costs of maintaining quality healthcare services, we have implemented the following financial policy which we ask that you read, accept, and acknowledge.

REGARDING COMMERCIAL INSURANCES:

- **We must have a copy of your current insurance card.** Therefore, it is the responsibility of the patient to make sure you offer your insurance card to the Receptionist for copying if your insurance has changed since your last visit.
- **If you have an HMO plan with whom we have a contract,** a proper referral from your Primary Care Physician is necessary for you to be seen for both testing and regular office visits. This referral must contain the diagnosis, number of visits allowed, physician to be seen, and have an expiration date. It is the patient's responsibility to keep track of the number of remaining referrals. You may call our office at any time to verify this information prior to your visit. **If you are seen without a valid referral, you will be responsible for the costs associated with the office visit.**
- **If you have a copay associated with your insurance,** you will be responsible for the payment of that copay on the day of your appointment. All copays are collected upon arrival.
- **If you have not met your deductible or if you have a co-insurance that remains after the insurance company has paid their portion,** you will be responsible for this balance and payment will be expected.
- **If your insurance requires a copay for testing,** you are responsible for payment of both the copays.
- **If your insurance has lapsed in coverage,** or is not in effect at the time of service, you will be responsible for payment of services.

REGARDING MEDICARE PATIENTS:

- **Patients are responsible for meeting their annual deductible each year.**
- **Once the deductible has been met,** patients without secondary insurance will be required to pay their 20% portion at the time of their visit.
- **If you have secondary/supplementary insurance,** it is the responsibility of the patient to provide our staff with a copy of that card.
- **We will file with secondary/supplementary carriers.** However, in the event that the secondary insurance does not pay, patients will be responsible for the balance.

NON-PARTICIPATING INSURANCES AND SELF-PAY PATIENTS:

- **If you have presented us with a health insurance card with which we do not participate,** you will be expected to pay 100% of our billed amount at the time the services are rendered.

- **Once payment is remitted,** the claim will be submitted to your insurance carrier on your behalf. Any reimbursement due to you for out of network benefits should be sent directly to you. If your insurance company mails the payment to our office, a refund check will be sent to you in the amount paid by the insurance company.

PARTIAL PAYMENTS/PAYMENT PLANS:

- **Partial payments will only be accepted if prior arrangements have been made.**
- **If you wish to proceed with the prescribed treatment plan** and would like to set up a payment plan, this can be arranged with our office. Payment plans can only be set up with a credit card/debit card on file.
- **Once a payment plan is arranged,** payments must be made consistently or the balance will be considered delinquent. You may be subject to finance charges or eventually turned over to our collection agency.

DELINQUENT ACCOUNTS:

- **Delinquent accounts will be subject to monthly billing charges until the account is settled in full.**

OUR CANCELLATION POLICY:

- **We require 24 hours notice for all canceled appointments** or your account will be charged. Please be aware that this charge is your responsibility and is not covered by your insurance.
- **There will be a $50.00 charge for all follow-up office visits no-shows and $100.00 charge for new patient no-shows.**

INSURANCE AUTHORIZATION AND ASSIGNMENT (FOR ALL PATIENTS):

I request payment of Medicare and/or participating managed care products be made payable to the Orthopedic Institute of North Texas, PLLC on my behalf for any services provided to me by the Practice. I authorize the release of any information about me to Medicare and/or other participating managed care products and its agents that may be needed to determine these benefits.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**