

Advanced Orthopaedic Specialists, PC

110 Hospital Road, Suite 204, Prince Frederick, MD 20678

Patient Information	Patient Name	
	Address	
	City, State Zip Code	
	Telephone Number	E-mail Address: _____
	Date of Birth	
	Sex	(Check One) <input type="checkbox"/> Male <input type="checkbox"/> Female
	Employer Name	
	Employer Address	
	City, State Zip Code	
	Employer Phone Number	
	Social Security Number	
	Marital Status	(Check One) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
	Relation to Responsible Party	(Check One) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
	Referred By or Family Physician	(Name) _____ (Phone) _____
Responsible Party	Responsible Party Name	
	Address	
	City, State Zip Code	
	Telephone Number	
	Date of Birth	
	Sex	(Check One) <input type="checkbox"/> Male <input type="checkbox"/> Female
	Employer Name	
	Employer Address	
	City, State Zip Code	
	Employer Phone Number	
	Social Security Number	
Marital Status	(Check One) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Primary Insurance Information	Insurance Carrier Name	
	Address	
	City, State Zip Code	
	Telephone Number	
	Name of Insured	
	Insured's Date of Birth	
	Policy Number	
Secondary Insurance Information	Insurance Carrier Name	
	Address	
	City, State Zip Code	
	Telephone Number	
	Name of Insured	
	Insured's Date of Birth	
	Policy Number	
Group Number		

Emergency Contacts	Primary Contact Name	
	Address	
	City, State Zip Code	
	Telephone Number	
	Secondary Contact Name	
	Address	
	City, State Zip Code	
	Telephone Number	
(Please inform your emergency contacts that you have given our office their names and information)		
Accident Related Visit	Is Visit Accident Related?	(Check One) <input type="checkbox"/> Yes (Complete Entire Section) <input type="checkbox"/> No (Skip This Section)
	Work or Auto Accident	(Check One) <input type="checkbox"/> Work Related <input type="checkbox"/> Automobile
	Date of Injury	
	Work Comp/Auto Ins Company	
	Work Comp/Auto Ins Address	
	City, State Zip Code	
	Employer at Time of Injury	
	Employer Address	
	City, State Zip Code	
Telephone Number		

Authorization to Treat: I hereby grant permission to the physicians and staff of Advanced Orthopaedic Specialists to perform any necessary procedures to treat the medical condition(s) for which I am seeking assistance. I understand that, except in an emergency situation, the staff will discuss with me my treatment options and that I will have the opportunity to accept or refuse specific treatments at that time.

Authorization to Release Information: I hereby authorize any holder of medical information about me to send to my insurance carrier or sponsoring agency or to the Social Security Administration or its intermediaries or carriers, when relevant, any such information that is requested by them needed for the processing of insurance benefit claims.

Assignment Of Benefits: I certify that the information I have given is correct. I hereby authorize payment to Advanced Orthopaedic Specialists of the benefits payable to me and to my physician(s). In applying for payment under Title XVIII of the Social Security Act, I request payment of authorized benefits be made on my behalf to those who accept this assignment. I further understand that I am responsible for any charges not covered or payable by this assignment. Even though Advanced Orthopaedic Specialists accepts assignment of insurance company payments, insurance carriers occasionally send payment checks to the patient for services rendered by the physician. I agree to forward any such payments I receive to Advanced Orthopaedic Specialists as soon as I receive them.

Charges for Services: The charges for the Advanced Orthopaedic Specialists are for the physician's professional fees and services. These charges do not include surgery center or hospital facility fees. The facility fees will be billed separately by the facility.

Payment for Services: As a courtesy to you, we will file claims with your insurance company. Monthly statements are mailed to patients only if they are responsible for some portion of the bill. Patients who have no insurance coverage, should be aware that payment for service is due on the day you are seen. A discount will be given for full payment on the day of your visit, and we accept payment by Visa and Master Card. If necessary, you may make monthly payment arrangements contingent on your credit history. Please call our billing agency at 1-800-427-7487 with any questions regarding your Advanced Orthopaedic Specialists account.

Patient Responsibility for Payment: I understand that my insurance coverage is a contract between my insurance carrier and me, NOT between the insurance carrier and the Advanced Orthopaedic Specialists. Ultimately, all fees are my responsibility. Should timely payments not be made on my account, I authorize Advanced Orthopaedic Specialists to retain the services of an attorney or collection agency to assist with the collection. Any expenses incurred by the Advanced Orthopaedic Specialists for such action shall become an additional liability for which I assume responsibility.

I have received the **Notice of Privacy Practices**.

Patient (or Parent/Guardian) Signature

Date

Please make sure we have an up-to-date copy of your insurance cards(s).