



PRINT CLEARLY
FILL OUT ALL SPACES

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Welcome To Our Office

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|--|---------------------|----------------------------|----------------------------------|----------------|--------|----------------|---|---|
| PATIENT'S NAME (PLEASE PRINT) | | STREET ADDRESS (PERMANENT) | | | APT. # | CITY AND STATE | | |
| ZIP CODE | PATIENT'S EMPLOYER | | OCCUPATION (INDICATE IF STUDENT) | | | CELL/BEEPER # | | |
| EMPLOYER'S STREET ADDRESS | | | CITY AND STATE | | | ZIP CODE | | |
| HOME PHONE # | BUS. PHONE # EXT. # | BIRTHDATE | AGE | S.S. # | | MARITAL STATUS | | SEX |
| | | | | | | S | M | OTHER |
| | | | | | | | | <input type="checkbox"/> M <input type="checkbox"/> F |
| STREET ADDRESS (SEASONAL) | | | | | APT. # | LOCAL PHONE # | | |
| SPOUSE OR PARENT'S NAME | | | | S.S. # | | BIRTHDATE | | |
| SPOUSE OR PARENT'S EMPLOYER | | | OCCUPATION (INDICATE IF STUDENT) | | | CELL/BEEPER # | | BUS. PHONE # |
| EMPLOYER'S STREET ADDRESS | | | CITY AND STATE | | | ZIP CODE | | |
| *SPOUSE'S STREET ADDRESS, IF DIVORCED OR SEPARATED | | | | CITY AND STATE | | ZIP CODE | | HOME PHONE # |

Please Read: PAYMENT IS DUE AT TIME OF VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR BUSINESS OFFICE. IF YOU ARE WORKERS COMPENSATION, PAYMENT IS NOT REQUIRED FROM YOU PROVIDED YOU SUPPLY US WITH THE "NOTIFICATION OF INJURY" FORM PROVIDED BY YOUR EMPLOYER. INSURANCE CLAIM FORMS WILL BE FILED AS A COURTESY TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS, HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE UNLESS PROHIBITED BY LAW.

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|--|--|---|--------------------|---|---------------|-------------------|---------|
| PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE | | STREET ADDRESS, CITY, STATE, ZIP CODE, HOME PHONE # | | | | | |
| WERE YOU INJURED ON THE JOB? <input type="checkbox"/> YES <input type="checkbox"/> NO | | DATE OF INJURY | WORK COMP. CLAIM # | | | | |
| WAS AN AUTOMOBILE INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | DATE OF INJURY | NAME OF ATTORNEY | | | | |
| POLICY HOLDER'S NAME | | | S.S. # | | DATE OF BIRTH | | |
| NAME OF INSURANCE CO. | | | POLICY NUMBER | | GROUP NUMBER | | |
| ADDRESS OF INSURANCE CO. | | | CITY AND STATE | | ZIP CODE | | |
| NAME OF SECONDARY INS. (IF APPLICABLE) | | | POLICY NUMBER | | GROUP | | |
| ADDRESS OF INSURANCE CO. | | | CITY AND STATE | | ZIP CODE | | |
| WERE X-RAYS TAKEN OF THIS INJURY OR PROBLEM? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | IF YES, WHERE WERE X-RAYS TAKEN? (HOSPITAL, ETC.) | | DATE X-RAYS TAKEN | |
| HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE? INCLUDE NAME OF PHYSICIAN AND FAMILY MEMBER | | | | | | | |
| WHOM MAY WE THANK FOR REFERRING YOU? | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | PHONE # |

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder _____
 I request that payment of authorized Medicare/other insurance company benefits be made to Palm Beach Sportsmedicine for any services furnished me by the party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other Insurance company claim.
 I understand that I am financially responsible for all charges whether or not paid by insurance, where allowed by law. It is further agreed that any cost of collection including collection agency fees shall be paid by the undersigned.
 I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insured or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination by Medicare/ other insurance company. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). It is mandatory to cooperate with the provider and the insurance company to facilitate the payment of the claim. All questions about fees should be asked prior to services being rendered. The person responsible for payment, please sign below having read and understanding all the above regarding payment.

Signature _____ Date _____