Ortho MA
ORTHOPEDIC URGENT CARE
53 Southampton Rd. Westfield, MA 01085
www.orthoma.org • (413) 836-7846

PT NUMBER _____
DATE _____

PATIENT REGISTRATION

LAST NAME: _____ FIRST NAME: _____ MI: ____

• IF PATIENT IS A MINOR (UNDER 18), RESPONSIBLE PARTY IS: _____

DOB: ____/____/____ SEX (M/F): ____ SSN: _____ *RACE: _____ LANGUAGE: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMAIL: _____

NAME OF EMPLOYER/SCHOOL: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE: _____ **ID#:** _____

ARE YOU THE SUBSCRIBER? ☐ Y ☐ N — *If no, please provide information below:*

NAME OF POLICY HOLDER: _____ DOB: ____/____/____ SEX (M/F): ____

ADDRESS: _____

SSN: _____ RELATIONSHIP TO POLICY HOLDER: _____

NAME OF SECONDARY INSURANCE: _____ **ID#:** _____

ARE YOU THE SUBSCRIBER? ☐ Y ☐ N — *If no, please provide information below:*

NAME OF POLICY HOLDER: _____ DOB: ____/____/____ SEX (M/F): ____

ADDRESS: _____

SSN: _____ RELATIONSHIP TO POLICY HOLDER: _____

IF APPLICABLE - ATTORNEY INFORMATION

NAME OF ATTORNEY: _____

STREET ADDRESS: _____ PHONE: _____

CITY, STATE, ZIP: _____

AUTHORIZATIONS

I give permission to Ortho MA to disclose my Protected Health Information to the following individual(s). I hereby understand that this listing remains in effect unless revoked by me in writing.

NAME: _____ PHONE: _____ RELATIONSHIP: _____
(other than patient)

NAME: _____ PHONE: _____ RELATIONSHIP: _____
(other than patient)

**This information is now a federal mandate.*

(continued on back)

I give permission to Ortho MA to leave information and instructions on my answering machine and cell phone voicemail. I hereby give permission for disclosure, during my examination only, of my Protected Health Information to any individual I allow to accompany me into the examination room. I also understand that by providing my email, I am allowing the transmittal of my Protected Health Information.

I acknowledge that I have received a copy of Ortho MA's Notice of Privacy Practices. I hereby authorize Ortho MA to release information acquired in the course of my examination and/or treatment to my primary care physician, a consulting physician, and my health insurance carrier as part of the normal process in the delivery of healthcare.

AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PHYSICIAN

I hereby authorize payment directly to Ortho MA for all medical benefits otherwise payable to me under the terms of my insurance policy. I agree to allow Ortho MA to submit claims and required treatment information to my insurance company or other third-party payment program for my care.

STATEMENT OF FINANCIAL RESPONSIBILITY

I am responsible for any deductibles or co-payments designated by my insurance. I am responsible for any non-covered services, including durable medical equipment, as well as obtaining and maintaining a current referral and/or prior authorization. I fully understand that I am responsible for paying for services rendered, including reasonable attorney's fees and the cost of collection in the event of default. Failure to meet my financial obligations can result in further collection actions.

I HAVE VERIFIED THAT ALL INSURANCE AND DEMOGRAPHIC INFORMATION PROVIDED AT REGISTRATION IS ACCURATE. I UNDERSTAND AND AGREE THAT THE ABOVE AUTHORIZATIONS REMAIN VALID INDEFINITELY UNLESS OTHERWISE SPECIFIED.

SIGNATURE: _____ DATE: _____

(patient or legal guardian)

If the signature above is not the patient's, please indicate your relationship to the patient:

RELATIONSHIP: _____ DATE: _____