OrthoMA
ORTHOPEDIC URGENT CARE

53 Southampton Road • Westfield, MA 01085
www.orthoma.org • (413) 83 - ORTHO

PT NUMBER_____

DATE _____

PATIENT REGISTRATION

LAST NAME: _____ FIRST: _____ M.I. _____

**IF PATIENT IS A MINOR, RESPONSIBLE PARTY IS:_____

D.O.B.: ____/____/____ SEX (M/F): ____ SSN: _____ *RACE: _____ ETHNICITY: _____

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

HOME PHONE:_____ CELL: _____ WORK:_____ EMAIL:_____

NAME OF EMPLOYER/SCHOOL:_____

PRIMARY CARE PHYSICIAN:_____ ADDRESS: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: (NAME)_____ ID#:_____

**SUBSCRIBER: Y ☐ / N ☐ IF NO — PLEASE PROVIDE INFORMATIONBELOW:

NAME OF POLICY HOLDER:_____ D.O.B.: ____/____/____ SEX (M/F): _____

ADDRESS: _____

SSN: _____ RELATIONSHIP TO POLICY HOLDER:_____

SECONDARY INSURANCE: (NAME)_____ ID#:_____

**SUBSCRIBER: Y ☐ / N ☐ IF NO — PLEASE PROVIDE INFORMATIONBELOW:

NAME OF POLICY HOLDER:_____ D.O.B.: ____/____/____ SEX (M/F): _____

ADDRESS: _____

SSN: _____ RELATIONSHIP TO POLICY HOLDER:_____

IS THIS RELATED TO: WORKERS' COMP? Y ☐ / N ☐ AUTO? Y ☐ / N ☐

IF ACCIDENT RELATED – PLEASE PROVIDE INFORMATION

▫WORKERS' COMP ▫ AUTO — INJURY TO WHAT BODY PART? _____

DATE OF INJURY:____/____/____ WORKERS' COMP/AUTO CLAIM NUMBER:_____

ADJUSTER: _____ PHONE:_____ FAX: _____

WORKERS COMP /AUTO/OTHER INSURANCE CARRIER:_____

BILLING ADDRESS:_____ CITY, STATE, ZIP _____

ATTORNEY INFORMATION

NAME OF ATTORNEY:_____

ADDRESS: _____ PHONE #:_____

CITY, STATE, ZIP _____

*This information is now a federal mandate.

(continued on back ...)

AUTHORIZATIONS

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

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

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

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 by providing my email I am allowing transmittal of my Protected Health Information.

I acknowledge that I have received a copy of Ortho MA Notice of Privacy Practices. I hereby authorize New England Orthopedic Surgeons 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/surgical benefits, otherwise payable to under the terms of my insurance policy. I agree to allow Ortho MA to submit claim 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 to pay for services rendered, including reasonable attorney's fees and cost of collection in the event of default. Failure to meet your financial obligations can result in further collection actions.

I HAVE VERIFIED THE ACCURACY OF ALL INSURANCE AND DEMOGRAPHIC INFORMATION WHICH I PROVIDED AT REGISTRATION. I AGREE THAT ALL OF THE ABOVE AUTHORIZATIONS ARE VALID INDEFINITELY UNLESS OTHERWISE STATED.

SIGNATURE: _____ DATE: _____

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

RELATIONSHIP:_____ DATE: _____