ACCT. TYPE_____

Central Nebraska Orthopedics

DOCTOR _____

DATE_____ AGE_____ DATE OF BIRTH_____ HEIGHT_____ WEIGHT_____ SEX_____

PATIENT'S NAME:_____ SS #_____
LAST FIRST INITIAL SOCIAL SECURITY #

ADDRESS:_____
STREET CITY STATE ZIP CODE

HOME PHONE: (____) _____ SPOUSE/PARENT NAME:_____

CELL PHONE: (____) _____ CELL PHONE: (____) _____

E-MAIL ADDRESS:_____

PATIENT'S EMPLOYER:_____ (____)_____
(IF MINOR, FATHER'S EMPLOYER) Work Phone

EMPLOYER ADDRESS:_____

SPOUSE EMPLOYER: _____ (____)_____
(IF MINOR, MOTHER'S EMPLOYER) Work Phone

EMPLOYER ADDRESS:_____

*IN CASE OF EMERGENCY CONTACT: _____ PHONE: (____) _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ POLICY #: _____ GROUP #: _____
POLICY HOLDER'S NAME: _____ BIRTHDATE: _____ SS #: _____

SECONDARY INSURANCE _____ POLICY #: _____ GROUP #: _____
POLICY HOLDER'S NAME: _____ BIRTHDATE: _____ SS #: _____

THIRD PARTY: _____ POLICY #: _____ GROUP #: _____
POLICY HOLDER'S NAME: _____ BIRTHDATE: _____ SS #: _____

REASON FOR VISIT: _____ FAMILY PHYSICIAN _____

NAME OF DOCTOR WHO REFERRED YOU: _____ PRIOR X-RAYS FOR PROBLEM: ____ YES ____ NO

PRIOR TREATMENT FOR PROBLEM:_____ WHERE: _____ DATE: _____

IS THIS MEDICAL CONDITION DUE TO AN ACCIDENT OR INJURY? _____YES _____ NO

IF YES WAS IT: ( ) Work Related ( ) Auto ( ) Injured in own home ( ) Other

DATE: _____ PLACE OF INJURY: _____

BRIEF DESCRIPTION OF ACCIDENT_____

_____

HAS FIRST REPORT OF INJURY BEEN FILED WITH EMPLOYER? _____YES _____ NO

ATTORNEY'S NAME:_____ DO YOU HAVE LITIGATION PENDING:____ YES ____ NO

AUTHORIZATION (Assignment of benefits/financial agreement):

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Central Nebraska Orthopedics, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney fees. I hereby authorize Central Nebraska Orthopedics to release all information to insurance companies, attorneys, or other physicians to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

HIPAA PRIVACY NOTICE:

The signature below acknowledges receipt of a copy of Central Nebraska Orthopedics notice of privacy practices.

CONSENT TO MEDICAL TREATMENT:

Knowing that I have (or the patient listed above has) a condition requiring diagnosis and medical treatment, do hereby voluntarily consent to such diagnostic procedures, x-rays and to such medical treatment rendered by Central Nebraska Orthopedics.

Interest at the rate of 16% per annum will be charged on all accounts that remain unpaid 90 days after rendition of the statement of account.

Date:_____ Signature_____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY