MOTIONORTHOPAEDICS

Patient Information

Patient Name:

Social Security #:

Address:

City, State & Zip Code:

Date of Birth:

Gender:

Employment / Student Status:

- ☐ Full time employed
- ☐ Part time employed
- ☐ Unemployed
- ☐ Retired
- ☐ Full time student
- ☐ Part time student

Employer Name & Address:

Occupation:

Please circle best phone number to reach you at:

- ☐ **Cell #:**
- ☐ **Home #:**
- ☐ **Work #:**

Email Address:

Referring Physician/Health Professional:

Referring Physician Phone/Address:

Primary Care Physician:

Primary Care Phone #:

Emergency Contact Name & Phone:

Relationship to Patient:

☐ **Married** ☐ **Single** ☐ **Other**

Spouses Name:

Financially Responsible Person (if different from above)

Full Name:

Address:

City, State, Zip Code:

Date of Birth:

Employer Name:

Social Security #:

Cell #

Home #:

Work #:

Relationship to the patient (check one):

☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Date Reviewed _____ Initials _____

MOTIONORTHOPAEDICS

Insurance Company Information Motion Orthopaedics

Primary Insurance Company Name:		**Secondary Insurance Company Name:**	
Address, City, State & Zip:		**Address, City, State & Zip:**	
Policy Holder:	**Date of Birth:**	**Policy Holder:**	**Date of Birth:**
Policy Holder Employer:	**Policy Holder SSN:**	**Policy Holder Employer:**	**Policy Holder SSN:**
Policy Number:	**Group Number:**	**Policy Number:**	**Group Number:**
Relationship to the Patient (check one): ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other		**Relationship to the Patient (check one):** ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other	

Medicare Lifetime & Medigap Signature on File:

I request that payment of authorized Medicare, Medigap, and all other insurance company benefits be made on my behalf to Motion Orthopaedics for any services furnished to me by the provider. I authorize any holder of medical information about me to be released to my health insurance company or the Health Care Financing Administration and its agent's needed to determine these benefits or benefits payable for related services.

Advanced Beneficiary Notice of Medicare Non-Coverage and Terms of any other insurance:

I understand that when accepting any treatment or durable medical goods from my provider the charges will be billed to my insurance company or Medicare for an official decision on payment, which is sent to me in a Summary Notice. I understand that if my insurance or Medicare doesn't pay, I am responsible for payment, but I can appeal to my insurance company or Medicare by following the directions in the Summary Notice. If my insurance or Medicare does pay Motion Orthopaedics will refund any payments I made to you, less co-pays and deductibles. I understand it is my responsibility to know the terms of my insurance plan. If I do not present my current insurance card or any required referral numbers or forms from my primary care physician for specialty care at the time of every visit I am choosing to go outside my plan. Additionally, there may be charges that are not covered by my insurance company. I understand I am responsible for all charges incurred by me, and I further agree to prompt payment of any services billed in these situations.

I authorize payment of medical benefits provided by my medical insurance described on a standard health form to Motion Orthopaedics for services provided during my care and treatment as described on the standard health care form information necessary to process claims. I understand that I am financially responsible for the charges covered by this authorization, and I will be responsible for any collection fees or cost associated with collections. I understand I may request a copy of and/or review the Notice of Privacy Practices at any time. I give the physicians of Motion Orthopaedics permission to view my prescription history from external sources including pharmacies, other physicians, hospitals and my health insurance.

Signature: _____ **Date:** _____

Authorization & Consent For Release of Information:

This form allows Motion Orthopaedics to release records from our office to discuss medical treatment and any billing issues with the following people:

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

May we leave voice mail messages on your telephone? ☐ Yes ☐ No If Yes: Check all that apply as able to leave a message:

May we text your cell phone? ☐ Yes ☐ No Cell Phone # _____ ☐ Home # ☐ Cell # ☐ Work #

May we call your cell phone regarding any billing issues? ☐ Yes ☐ No

Preferred Pharmacy Name/Address: _____ Pharmacy Phone No.: _____

Authorization to Release Information:

Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "Confidential". I permit the release of all information indicated above including test results and/or diagnosis and treatment information, if any, concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV and other communicable diseases.

I understand that neither Motion Orthopaedics nor any affiliated healthcare providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization if I chose to do it.

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will expire ninety (90) days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax or bring a letter in person stating that I want to cancel this Authorization.

Patient/Legal Representative Signature _____ **Date:** _____ **Relationship:** _____