



# COSM Patient Information

Patient #: \_\_\_\_\_

Today's Date \_\_\_\_\_

Updated \_\_\_\_\_

 BOULDEN  FORMANEK  JACOBSON  LEE  BAHL  YANISH  CRITES  FISH

## PATIENT

Patient Name \_\_\_\_\_  
First Middle Last Maiden

Address \_\_\_\_\_ Apt \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex: M / F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: S M D W Social Security # \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Language \_\_\_\_\_ E-mail Address \_\_\_\_\_

Family Physician \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Name / City Phone( ) \_\_\_\_\_ Extension \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*(Complete if patient is a dependent – if not go to Employer Information)*

Mother's Name \_\_\_\_\_ Employer \_\_\_\_\_ Phone( ) \_\_\_\_\_

Father's Name \_\_\_\_\_ Employer \_\_\_\_\_ Phone( ) \_\_\_\_\_

## EMERGENCY CONTACT

Spouse's Name \_\_\_\_\_ Cell ( ) \_\_\_\_\_ Employer \_\_\_\_\_ Work ( ) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone( ) \_\_\_\_\_ Cell( ) \_\_\_\_\_  
(Not living with you)

## DESCRIPTION OF INJURY OR ILLNESS

## RESPONSIBLE PARTY

Problem being seen for: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Scene of injury \_\_\_\_\_

Explain injury \_\_\_\_\_

Work-related injury? Y / N If work related, "First Report of Injury" filed? Y / N Date filed: \_\_\_\_\_

Motor vehicle accident? Y / N Responsible party \_\_\_\_\_

Attorney Involved? Y / N Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

## INSURANCE

### PRIMARY INSURANCE

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Co-Pay \_\_\_\_\_

Relationship to Subscriber \_\_\_\_\_

### SECONDARY INSURANCE

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Co-Pay \_\_\_\_\_

Relationship to Subscriber \_\_\_\_\_

### WORKER'S COMPENSATION (For work-related injury)

Company \_\_\_\_\_

Contact person \_\_\_\_\_ Phone( ) \_\_\_\_\_

Claim number \_\_\_\_\_

### LIABILITY INSURANCE (For motor vehicle injury or third party)

Company \_\_\_\_\_

Contact person \_\_\_\_\_ Phone( ) \_\_\_\_\_

Claim number \_\_\_\_\_

I Authorize the following persons to receive verbal information regarding my account or medical records:(i.e. Spouse, fiancée, Children, etc.)  
\_\_\_\_\_How did you hear about Capital Orthopaedics & Sports Medicine PC?  Friend  Internet Search  Physician  Radio  
 Television Commercial  Yellow Pages/Phone Book  Other

\*\*\*\*DOCTOR'S USE ONLY\*\*CC DICTATION\*\*\*\*

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## FINANCIAL POLICY

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**FOR PATIENTS WITH INSURANCE:** As a courtesy, we bill most insurance companies. However, this is not a guarantee of benefits or payments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 90 days of billing, professional fees are due and payable in full.

**CO-PAYMENTS:** All co-pays will be collected at time of service. We accept all major credit cards, cash, or check. Failure to pay co-pay at time of service may result in an additional service charge.

**SURGERY FEE:** Our billing department must make arrangements prior to any procedure. Please contact your insurance company regarding your benefits. Arrangements will be made prior to surgery for deductible payments to be processed on the date of surgery. Coinsurance amounts will be estimated and arrangements for payments will be made prior to the surgery date.

**NONCOVERED SERVICE:** Any care not paid for by your existing insurance coverage will require payment in full at the time of service or upon notice of your insurance claim denial.

**WORKER'S COMPENSATION:** If your injury is work related, we will need prior approval from the carrier and/or employer.

**MISSED APPOINTMENTS:** Failure to give a 24 hour notice of cancellation or rescheduling will result in the following: First incident – No fee; Second incident – Physician review and determination of possible fee; Third and/or subsequent incident - \$25.00 fee.

**FINANCE CHARGES:** A service fee of 1.5% monthly or up to a maximum of 18% annually will be assessed to unpaid balances. Unpaid balances over 90 days will be transferred to a collection agency. The collection agency will report to the credit bureau which may be damaging to your credit.

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Signature

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Date

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**RELEASE OF INFORMATION:** I hereby authorize Capital Orthopaedics & Sports Medicine P.C. (COSM) to release information from my medical records as may be required or requested by my insurance company, employer, or any other persons liable to COSM for payment of services. I authorize COSM to act as my agent in filing insurance claims on my behalf. I directly assign to COSM all insurance benefits. I understand by signing this I am ultimately financially responsible for all charges incurred.

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Signature

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Date

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## MEDICARE PATIENTS ONLY

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**SIGNATURE ON FILE:** I request payment of authorized Medicare benefits be made by me or on my behalf to Capital Orthopaedics & Sports Medicine, PC for any services furnished to me by the listed provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the CMS-1500 form or elsewhere on the approved claims forms or assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

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Signature

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Date

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