



COSM Patient Information

Account #: _____
Today's Date _____
Updated _____

WRB TSF WCJ MSL DJB GJY BMC MDF

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 () _____
 E-mail Address _____
 Family Physician _____ Referring Physician: _____
Name / City Name / City
 Patient's Employer _____ 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 _____ Relationship to Subscriber _____	SECONDARY INSURANCE _____ ID# _____ Group# _____ Subscriber's Name _____ Date of Birth _____ Relationship to Subscriber _____
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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 _____
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I Authorize the following persons to receive verbal information regarding my account or medical records:(i.e. Spouse, fiancée, Children, etc.)

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

FINANCIAL POLICY

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.

COLLECTION FEE: Unpaid balances over 90 days will be transferred to a collection agency. The account balance will be increased 35% and/or any additional fees incurred to collect the balance applied by the collection agency. The collection agency will report to the credit bureau which may be damaging to your credit.

Signature

Date

MEDICARE PATIENTS ONLY

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.

Signature

Date