Today's Date:	DMOS ORTHOPAEDIC CENTERS **Patient Registration Form**	Medical Records #:

PLEASE PRINT **-- INFORMATION TO BECOME PART OF YOUR CONFIDENTIAL MEDICAL RECORD**

PATIENT

Name (First, Middle, Last)	Social Security # 000-00-0000	___ Male ___ Female	Date of Birth _____/_____/_____

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Legally Separated

Race _____ Ethnicity _____ Language _____

Patient Address (Street / Apt #)	City, State, Zip Code

E-mail Address	Home Phone (000) 000-0000	Work Phone (000) 000-0000	Cell Phone (000) 000-0000

___ Employed ___ Self-Employed ___ Unemployed ___ Disabled ___ Retired ___ Part-Time Student ___ Full-Time Student

Employer	Occupation (Title)
Referring Physician	Family Physician

Responsible Party Information (if patient is under age 18)

GUARANTOR

Name (First, Middle, Last)	Social Security # 000-00-0000	___ Male ___ Female	Date of Birth _____/_____/_____

Relationship to Patient:

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Legally Separated

Race _____ Ethnicity _____ Language _____

Address (Street / Apt #)	City, State, Zip Code

E-mail Address	Home Phone (000) 000-0000	Work Phone (000) 000-0000	Cell Phone (000) 000-0000

___ Employed ___ Self-Employed ___ Unemployed ___ Disabled ___ Retired ___ Part-Time Student ___ Full-Time Student

Employer	Occupation (Title)

Insurance Information - ***YOUR INSURANCE CARD WILL BE REQUIRED AT CHECK-IN.***

INSURANCE

Primary Insurance (BCBS, Medicare, etc.)	Group Number	Identification Number	Group Name or Employer (i.e.'ABC Company')

Cardholder's Full Name	Relationship to Patient	Cardholder's Social Security #	Cardholder's DOB _____/_____/_____

Secondary Insur. (BCBS, Medicare, etc.)	Group Number	Identification Number	Group Name or Employer (i.e.'ABC Company')

Cardholder's Full Name	Relationship to Patient	Cardholder's Social Security #	Cardholder's DOB _____/_____/_____

Emergency Contact Information

NOTIFY

Emergency Contact not listed above (First, Middle, Last)	Relationship to Patient	___ Male ___ Female

Home Phone (000) 000-0000	Work Phone (000) 000-0000	Cell Phone (000) 000-0000

Pharmacy Information

Preferred Pharmacy Name and Address	Phone (000) 000-0000

Nature of Illness or Injury

INJURY

Brief Description of Orthopaedic Illness or Injury. Please Indicate Location (Left / Right / Both	Date of Injury _____/_____/_____

Check Those That Apply: ___ Work Injury ___ Liability Accident ___ Motor Vehicle Accident ___ None

OVER PLEASE

OVER PLEASE

READ CAREFULLY AND SIGN NAME BELOW

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I authorize release of any medical information necessary to process this (these) insurance claim(s) and permit the following to be used in place of this original document for all federal, state, commercial, compensation, or liability insurance claims:

(1) a photocopy of other facsimile reproduction of this authorization, or
(2) use of a computer to indicate my signature is on file at clinic, and/or
(3) use of a computer to electronically transmit my claim for processing.

AUTHORIZATION TO ASSIGN MEDICAL BENEFITS TO CLINIC:

I certify that information I have provided related to my insurance coverage is both true and correct. I authorize my insurance company/group health plan (collectively the "Plan") to direct all payments for all professional and medical benefits directly to Des Moines Orthopaedic Surgeons, P.C. ("DMOS") as payment for services rendered by DMOS. Further, I assign all rights and benefits under my Plan related in any way to the services I've received to DMOS. This includes the right to raise claims for benefits under the terms of my plan; the right to obtain any documents or information I might be entitled to receive, such as requests under ERISA 104(b), for documents relevant to my claim for benefits, or any other documents or information I might be entitled to receive under any statute or Plan term; the right to sue for breach of fiduciary duty or for equitable relief under any section of ERISA 502(a); the right to challenge recoupment efforts; and any other right that I may have under my Plan, ERISA, or any other relevant law. This is a direct assignment of my rights under the Plan.

ERISA AUTHORIZATION:

I hereby designate, authorize, and convey to the physicians of DMOS to the fullest extent permissible under law and under the Plan, as that term is defined above, the right to act as my Authorized Representative to the extent that such right has not already properly been conveyed. This includes, but is not limited to, the right and ability to act on my behalf in connection with any claim, right, or cause of action that I may have under such Plan, and the right to act on my behalf in any claims filed under ERISA as provided in 29 C.F.R. §2560.503-1(b)(4) with respect to any healthcare expense incurred as a result of the services I received from physician(s) of DMOS, and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

ACKNOWLEDGEMENT OF INSURANCE LIMITATIONS:

Many insurance carriers require a written referral from a primary care physician (PCP) in advance of service (office visits, surgery, and diagnostic tests-- MRI). Patients, parents, or the guardians are responsible for (1) obtaining physician referrals and (2) contacting their insurance carrier to verify benefits in advance of service. I understand that having health insurance does not absolve me of my responsibility to ensure that my bills from the physicians of this Clinic are paid in full and that I am responsible for non-covered services, deductibles, co-insurance, and any penalties imposed by my insurance company on our physician for seeing patient's out-of-network. Co-payments are due at time of service.

ACKNOWLEDGEMENT OF PAYMENT RESPONSIBILITY:

Payment for medical services is between the Clinic (physician) and the patient. Payment is due in full according to the terms of this Clinic's credit policy. Therefore, I understand that this Clinic cannot accept responsibility for collecting or negotiating settlement on any disputed (1) health insurance claim, (2) worker's compensation claim, (3) accidental injury/illness liability claim, (4) claim where patient is/will be represented by an attorney, and/or (5) claim to be settled in a court of law.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE:

I understand I have a right to review DMOS's Notice of Privacy Practices prior to signing this document. DMOS's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of DMOS. The Notice of Privacy Practices for DMOS is also provided in the clinic registration area and on DMOS's website at www.dmos.com. This Notice of Privacy Practices also describes my rights and DMOS's duties with respect to my protected health information.

DMOS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing DMOS's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

ACKNOWLEDGEMENT OF PROHIBITION AGAINST VIDEOTAPING, PHOTOGRAPHING AND RECORDING OF ANY KIND:

I agree that I will not video or audio record my interactions with any DMOS practitioners or staff and that I am aware that DMOS has a policy that prohibits audio or video recording on its premises.

Signature of Patient or Personal Representative _____ Date _____

Name of Patient or Personal Representative _____

Description of Personal Representative's Authority / Relationship to Patient _____

THIS CLINIC ACCEPTS VISA, DISCOVER, MASTERCARD, PERSONAL CHECKS AND CASH.
CO-PAYMENTS ARE DUE AT TIME OF SERVICE.

THIS AREA FOR DMOS STAFF USE ONLY

I, _____, attempted to obtain the patient's acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so.

Reason acknowledgement not obtained_____

_____

DMOS Staff Signature _____ Date _____