| Today's Date: | Patient Registration<br>**Des Moines Orthopaedic Surgeons, P.C.** | Medical Records #: |
|---|---|---|

*PLEASE PRINT*

## INFORMATION TO BECOME PART OF YOUR CONFIDENTIAL MEDICAL RECORD

**Complete the following information carefully.**

### PATIENT

| Name (First, Middle, Last) | | | Home Phone (000) 000-0000 | Work Phone (000) 000-0000 |
|---|---|---|---|---|
| Street Address | | | City, State, Zip Code | |
| Age | Date of Birth (mm/dd/yy) | Gender<br>☐ Male<br>☐ Female | Marital Status<br>☐ Married ☐ Single<br>☐ Widowed ☐ Divorced | Social Security # 000-00-0000 |
| ☐ Employed ☐ Not Employed ☐ Student ☐ Retired ☐ Disabled | | | | |
| Employer | | | Occupation (Title) | |

**Responsible Party Information (If other than patient)**

| Name (First, Middle, Last) | | | Home Phone (000) 000-0000 | Work Phone (000) 000-0000 |
|---|---|---|---|---|
| Street Address | | | City, State, Zip Code | |
| Date of Birth | Relationship to Patient | Gender<br>☐ Male<br>☐ Female | Marital Status<br>☐ Married ☐ Single<br>☐ Widowed ☐ Divorced | Social Security #: 000-00-0000 |
| ☐ Employed ☐ Not Employed ☐ Student ☐ Retired ☐ Disabled | | | | |
| Employer | | | Occupation (Title) | |

### INSURANCE

**Insurance Information**

| **Primary** Insurance (BCBS, Medicare, etc) | Cardholder's Full Name | Relationship to Patient |
|---|---|---|
| Group Name or Employer (i.e. 'ABC Company') | Identification Number | Group Number |
| **Secondary** Insurance (BCBS, Medicare, etc) | Cardholder's Full Name | Relationship to Patient |
| Group Name or Employer (i.e. 'ABC Company') | Identification Number | Group Number |

***YOUR INSURANCE CARD WILL BE REQUIRED AT CHECK-IN. IF YOUR CARD IS NOT AVAILABLE, PLEASE CONTACT YOUR PHYSICIAN'S SECRETARY FOR ASSISTANCE.***

### NOTIFY

**Emergency Contact Information**

| Full Name of Emergency Contact (not living with you) | Relationship to Patient | Home Phone (000) 000-0000 |
|---|---|---|

### INJURY

**Nature of Illness or Injury**

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

| **Check Those That Apply:**<br>☐ Work Injury<br>☐ Liability Accident<br>☐ Motor Vehicle Accident | Date of Injury (mm/dd/yy) | If this is a work injury, has medical treatment been authorized by your employer?<br>☐ Yes ☐ No |
|---|---|---|
| | Name and Address of Company and/or Representative (i.e. claims adjuster) to Contact for Verification | Phone Number<br>Claim Number |
| Family Physician | | Referring Physician |

**OVER PLEASE** **OVER PLEASE**

## READ CAREFULLY AND SIGN NAME BELOW

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION:**
I authorize release of 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 provided relative to injury, illness, and insurance coverage is both true and correct. I authorize payment of insurance benefits or proceeds from any liability claim and legal/court settlement to be assigned to the physicians of this Clinic to the extent that their charges are paid in full.

**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. Patients are also responsible for non-covered services, deductibles, co-insurance, and any penalties imposed by their insurance company on our physician for seeing patients 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 PRACTICES:**
I understand I have a right to review Des Moines Orthopaedic Surgeons, PC's (DMOS) 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.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand DMOS will use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of DMOS.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. DMOS is not required to agree to the restrictions that I may request. However, if DMOS agrees to a restriction that I request, the restriction is binding on DMOS and its providers.

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.

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.***

## Other Information: