

Today's Date:



# 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		<input type="checkbox"/> Male	Date of Birth
				<input type="checkbox"/> Female	___/___/___
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> 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	
<input type="checkbox"/> Employed <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Part-Time Student <input type="checkbox"/> Full-Time Student					
Employer			Occupation (Title)		
Referring Physician			Family Physician		

GUARANTOR

Responsible Party Information (if patient is under age 18)					
Name (First, Middle, Last)		Social Security # 000-00-0000		<input type="checkbox"/> Male	Date of Birth
				<input type="checkbox"/> Female	___/___/___
Relationship to Patient:					
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> 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	
<input type="checkbox"/> Employed <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Part-Time Student <input type="checkbox"/> Full-Time Student					
Employer			Occupation (Title)		

INSURANCE

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

NOTIFY

Emergency Contact Information			
Emergency Contact not listed above (First, Middle, Last)		Relationship to Patient	<input type="checkbox"/> Male
			<input type="checkbox"/> Female
Home Phone (000) 000-0000		Work Phone (000) 000-0000	Cell Phone (000) 000-0000

INJURY

Pharmacy Information	
Preferred Pharmacy Name and Address	Phone (000) 000-0000
Nature of Illness or Injury	
Brief Description of Orthopaedic Illness or Injury. Please Indicate Location ( Left / Right / Both	Date of Injury
	___/___/___
Check Those That Apply: <input type="checkbox"/> Work Injury <input type="checkbox"/> Liability Accident <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> None	

OVER PLEASE

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**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.

**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. Co-payments are due at time of service.

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:**

I have had an opportunity 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 for treatment, payment of bills or in the performance of health care operations and studies of DMOS. The Notice of Privacy Practices for DMOS is also provided in the registration area and on DMOS's website (www.dmos.com). The Notice of Privacy Practices describes my rights and DMOS's duties with respect to my protected health information. I understand DMOS will use or may disclose my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, conduct follow up for continuity of care including surveys which may be used in studies or marketing and/or to conduct health care operations of DMOS. DMOS may also use my diagnostic record for studies which benefit society and are covered under nondisclosure and medically protected programs. 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 and studies 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. In addition, I, as the patient, may request and receive paper copies of my scope pictures, lab results, and/or orders when in clinic with the physician or physician care liason. Documents released to me, the patient, are solely for my personal records. I understand DMOS is not responsible for documentation once it is given to me in clinic. Additional documentation may be requested through administrative staff through the Release of Information Process.

**DISCLOSURE:**

DMOS may refer patients for services such as Physical Therapy, Durable Medical Equipment and/or MRI exams. I understand that I have the choice as to where I receive these services (at DMOS or an alternative provider) and I am not obligated to receive ancillary services at DMOS.

**ACKNOWLEDGEMENT OF PROHIBITION AGAINST VIDEOTAPING, PHOTOGRAPHING AND RECORDING OF ANY KIND:** I agree that I will not video, photograph or audio record while on DMOS property, any DMOS practitioners, property or staff. I am aware that DMOS has a policy that prohibits audio, photographing or video recording on its premises due to Privacy Laws.

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 \_\_\_\_\_