

Today's date: _____

Patient's Name: _____ Birth date: _____

Parent's name and phone number if child is patient: _____

Address: _____

Email: _____

Contact numbers: Home: _____ Cell: _____ Other: _____

Social Security #: _____ Occupation: _____

Patient's Employer: _____ Employer's phone number: _____

Family Physician: _____ Referring Physician: _____

Emergency Contact Name _____ Phone #: _____

Insurance Guarantor's Name: _____ Birth date: _____

Address: _____

How is the guarantor related to the patient? self spouse child legal guardian

Please present your insurance card to the front desk coordinator with completed paperwork.

Please read the following and sign below acknowledging the accuracy of this data and that you have read the form completely:

I consent to routine care, diagnostic procedures, administration of therapeutic injections, specimen collection as deemed necessary by the physician or his/her designee. I'm aware that the practice of medicine isn't an exact science, and I acknowledge that Allegiance Health has made no guarantees or assurance as to the result that may be obtained or the consequences that may follow any type of procedure, treatment or service.

I authorize Allegiance Health and it's physicians to release to any insurance payer, i.e. Medicare, Medicaid, BCBS, Workman's Compensation, or any party responsible for a portion of care that is rendered to me, such information as my patient records as required in order for Allegiance Health to receive payment for the services rendered. This consent is effective as long as you are a patient receiving care from this practice or there is still an outstanding bill that needs resolution.

I authorize payment directly to Allegiance Health and it's physicians of the insurance benefit otherwise payable to me, but not to exceed the balance due of Allegiance Health's regular charges for the time period care was received. I understand I am financially responsible for the charges not covered by an authorization or my insurance carrier.

I understand that if a person or entity receives my PHI and is not a health care provider or health place covered by federal privacy regulations, my healthcare information could be redisclosed by that person/entity and will likely no longer be protected by the federal privacy regulations.

I understand that treatment nor payment are conditional based upon the signing of this agreement.

Allegiance Orthopedics will strive to meet your health care needs, but does reserve the right to receive reasonable notice of request and reasonable time to complete the request.

I acknowledge that I have been informed by the staff of Allegiance Orthopedics that this practice doesn't participate with my insurance carrier and because of that I may be responsible for a greater deductible and/or copay **Please Initial:**

Please list the people we can discuss your billing inquiries, medical condition, diagnosis and lab reports with:		
Name:	Relation:	Birth date:
Name:	Relation:	Birth date:
Name:	Relation:	Birth date:

My signature below states confidential messages about my appointments, tests, surgery can be left with a family member, on your answering machine or voice mail. **If I disagree with this statement I have the right to cross this statement out and initial it.**

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____