DENVER METRO ORTHOPEDICS, P.C.
PATIENT INFORMATION

Name: _____ **DOB:** __ / __ / ____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____ **Work:** _____

Email: _____ **Preferred Contact:** □ Home □ Work □ Cell

SS# ____ - ____ - _____ **Language:** _____ **Race:** _____ **Marital Status:** _____

Sex: □ Male □ Female □ Undefined **Ethnicity:** □ Non-Hispanic □ Hispanic □ Other_____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Primary Care Doctor: _____ (M/F) Practice Name: _____

Phone: _____ Address: _____

Referring Care Doctor: _____ (M/F) Practice Name: _____

Phone: _____ Address: _____

Primary Insurance: _____ ID Number: _____

Group # _____ Policy Holder: □ Patient □ Spouse □ Parent □ Other _____

Primary Card Holder (if other than patient): _____ DOB: __ / __ / ____ Phone: _____

Secondary Insurance: _____ ID Number: _____

Group # _____ Policy Holder: □ Patient □ Spouse □ Parent □ Other _____

Primary Card Holder (if other than patient): _____ DOB: __ / __ / ____ Phone: _____

Worker's Comp: Date of Injury __ / __ / ____

Employer: _____ Employer's Phone: _____

Employer Address: _____ City_____ State ____ Zip_____

W/C Insurance Company _____ Claim # _____

Adjuster Name: _____ Adjuster Phone: _____

Previously Seen At: □ Concentra □ Health One □ Other _____

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Assignment of Benefits: Please remember that insurance contracts are made between the patient and the insurance company. Often the insurance does not provide full payment of medical costs. Payment of the bill is, therefore, your responsibility. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize payment of medical benefits to Denver Metro Orthopedics, P.C. for services to myself.

Date: _____

Sign: _____

"SIGNATURE ON FILE" will automatically print on your claim allowing your insurance to pay us directly.

Financial Acknowledgements: I understand that regardless of any insurance coverage or other potential co-guarantor or responsible party I am accepting full financial responsibility for payment of all charges for services provided to me, my spouse or dependents by this practice. I agree that if my employer, insurance carrier or plan sponsor denies payment to all of or any portion of my claim, I will be financially responsible for all outstanding charges. I agree to pay a minimum monthly billing charge of $5.00 or interest at the rate of 1.75% per month (whichever is greater) on any balance not paid within 30 days of the date of service. In addition, should my account become delinquent and assigned to a collection agency, I agree to pay an additional collection charge of 35% of the outstanding balance or a minimum of $40.00 (whichever is greater) to offset in part the collection agencies fee charged to this practice which may be calculated on a percentage basis. Should legal action be initiated by the collection agency, I agree to pay a collection charge of 50% of the outstanding balance as well as all costs and reasonable attorney fees incurred in such collection efforts by this office or our assignee.

TCPA Acknowledgment:

I authorize this office, its agents and assignees to contact me by telephone, text, SMS, and/or via an automated dialing system with live or recorded voice in connection with any of my accounts with this office and at any telephone number I have provided as of this date or in the future.

Date: _____

Sign: _____

Records Release: I hereby authorize the release of any information, including medical and billing information, by Denver Metro Orthopedics, P.C, to my referring doctor and insurance company.

Date: _____

Sign: _____

Notice of Privacy: I have received a copy of the Notice of Privacy Practice from Denver Metro Orthopedics, P.C.

Date: _____

Sign: _____

Prescription History: I authorize Denver Metro Orthopedics, P.C. to access my prescription history.

Date: _____

Sign: _____