**American Orthopaedic & Sports Medicine**
**Dr. Robert Clifford / Dr. Kevin Deitel / Dr. William Holland**

## *Patient Information*

Have you been here before? **Yes** **No** If so, when? _____
Social Security #_____ Primary Language_____
Mr./Mrs./Ms._____ ____ _____
First MI Last

_____
Street Address Apt./Sp. #

_____
City State Zip
Home Phone (___)_____ Cell(___)_____
Date Of Birth_____ Sex **M** **F** Marital Status **S** **M** **W** **D**
Spouse's Name:_____
Patient's Employer:_____Phone:_____
Address:_____City_____State_____Zip_____
What type of problem are we seeing you for today?_____
**Referral Source**:_____

## *Responsible Party information*

Name:_____Hm #_____Wk#_____
Address:_____City:_____State:_____Zip:_____
**Relationship to Patient**:_____

**Primary Insurance Name** _____
Billing Address _____
Name of Policy Holder _____Employer_____
D.O.B. of policy holder_____ SS# of policy holder _____
Policy #_____ Group #_____
Relationship to patient_____

**Secondary** Insurance_____
Billing Address _____
Name of Policy Holder _____Employer_____
D.O.B. of policy holder_____ SS# of policy holder_____
Policy #_____ Group #_____
Relationship to patient_____

**Insured patients:** **POS:** For POS (Point of Service) plans we are not contracted with the HMO benefit level of your POS plan. We will bill your insurance company under the POS benefit. This may result in a deductible and/or higher cost share being applied. Should your insurance company deny payment, you will be financially responsible. For, and in consideration of the care and treatment provided to the patient, I promise to pay at time of treatment, American Orthopedics & Sports Medicine, or agents, all charges for services rendered to or on behalf of the patient, I further assign my benefits to America Orthopedics & Sports Medicine under my medical insurance plan. **I understand that American Orthopedics & Sports Medicine does not bill third parties in the case of auto accidents or personal injuries and does not accept liens.** I understand that I am financially responsible for any outstanding balance not paid by my insurance company or for any benefits paid directly to me.
**HIPAA:** I have read and understand the HIPAA Protected Health Information Privacy Notice 3.5.1A. I understand that upon request a copy of the complete notice will be provided to me.

I hereby consent to and authorize the administration of all treatment that may be considered advisable or necessary in the judgment of the physician, and I hereby authorize American Orthopedics & Sports Medicine or contracted agents to release as determined appropriate for any lawful use without limitation, any medical information regarding the patient's history, condition, or treatment. I understand that I am entitled upon demand to a copy of this authorization. I agree to pay the doctor's usual fees for any legal testimony or work requested by myself, my attorney or agent, or any other entity which arises from any legal action to which I am a party.

_____ _____ _____
Signature of Patient unless patient is a minor Date Witness

_____
Relationship to patient