NORTHERN ORTHOPEDICS INC. - PATIENT INTAKE SHEET

FIRST NAME _____ MIDDLE INTIAL _____ LAST NAME _____ NICK NAME _____

___/___/___ DATE OF BIRTH __F __M SEX _____-____-_____ Social Security # _____ Email address

_____ Home Phone _____ Cell/Mobile Phone SPEAKS & UNDERSTANDS ENGLISH: YES or NO

_____ Mailing Address _____ City _____ State _____ Zip Code

- **Vocational Category:** (Mark one)

Employed Unemployed Retired On Disability Student Infant/Toddler

_____ Driver License # Status: Single Married Divorced Widowed Other

_____ Emergency Contact _____ Relation to patient _____ Phone

- **SERVICE CONNECTED VETERAN:** Yes No **IF YES,** has VA authorized services? Yes No
- **WORKER'S COMP CLAIM:** Yes • **AUTO ACCIDENT:** Yes • **OTHER ACCIDENT:** Yes

_____ EMPLOYER(IF WORKER'S COMP CLAIM) ____/____/_____ DATE OF INJURY _____ CLAIM #

_____ INSURANCE CARRIER _____ INSURANCE ADJUSTOR _____ INSURANCE PHONE #

PLEASE PRESENT ALL INSURANCE CARDS FOR SCANNING

- **PRIMARY INSURER:** _____ **INSURED:** _____
  BIRTHDATE OF INSURED:____/___/___ PATIENT'S RELATION TO INSURED: _____
- **SECONDARY INSURER:** _____ **INSURED:** _____
  BIRTHDATE OF INSURED:____/___/___ PATIENT'S RELATION TO INSURED: _____
- **TERTIARY INSURER:** _____ **INSURED:** _____
  BIRTHDATE OF INSURED:____/___/___ PATIENT'S RELATION TO INSURED: _____

AUTHORIZATION RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I REQUEST THAT PAYMENT UNDER THE MEDICAL INSURANCE PROGRAM BE MADE TO NORTHERN ORTHOPEDICS, FOR SERVICES FURNISHED TO ME, OR MY DEPENDENT. I AUTHORIZE NORTHERN ORTHOPEDICS TO RELEASE TO INSURANCE CARRIERS AND/OR AGENCIES INFORMATION NEEDED TO PROCESS MEDICAL CLAIMS. I FURTHER PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.I ACKNOWLEDGE AND ACCEPT RESPONSIBILITY FOR ALL CHARGES RESULTING FROM SERVICES RECEIVED FOR MY DEPENDENT OR MYSELF. I UNDERSTAND AND AGREE TO THE FOLLOWING:

I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF SERVICES.

I AM RESPONSIBLE FOR VERIFYING MY OWN INSURANCE COVERAGE AND ADVISING NORTHERN ORTHOPEDICS OF ANY REQUIREMENTS FOR PRIOR AUTHORIZATION.

NORTHERN ORTHOPEDICS MAY CONTACT MY INSURANCE AS PART OF ITS OFFICE PROCEDURES TO CONFIRM BENEFITS. NORTHERN ORTHOPEDICS IS NOT AN AGENT FOR ANY AGENCY NOR INSURANCE. IF FOR ANY REASON MY ACCOUNT IS IN LITIGATION OR GOES TO COLLECTIONS I AM AND WILL BE HELD RESPONSIBLE FOR ALL CHARGES, INTERESTS AND LEGAL FEES THAT MAY RESULT.

_____ **PATIENT/GUARDIAN (PRINT)** _____ **SIGNATURE** _____ **RELATION TO PATIENT** ___/___/___ **DATE**

_____ (Initial) I UNDERSTAND AND CONSENT TO PHOTOS, VIDEO, DIGITAL OR OTHER IMAGES BEING RECORDED TO DOCUMENT MY/DEPENDENT'S CARE, VERIFY TREATMENT AND TO SECURE PAYMENT FOR SERVICES.

Optional

_____ (Initial) I GIVE NORTHERN ORTHOPEDICS PERMISSION TO USE ANY OF THE ABOVE PHOTOS, VIDEOS OR OTHER IMAGES ON NORTHERN ORTHOPEDICS' WEBSITE (www.northo.com) OR IN ADVERTISING MATERIALS

_____ (Initial) I GIVE NORTHERN ORTHOPEDICS PERMISSION TO SPEAK TO THE PEOPLE LISTED BELOW REGARDING MEDICAL SERVICES AND BILLING INFORMATION FOR ME /OR MY DEPENDENT.

_____ NAME _____ RELATION TO PATIENT _____ NAME _____ RELATION TO PATIENT