Name: Date:

DOB:

Chart:

MidAmerica Hand to Shoulder Clinic | MidAmerica Orthopaedics | OrthoNow Orthopaedic Immediate Care

**Anton J. Fakhouri MD FACS FICS Gary A. Kronen MD Beverlee A. Brisbin MD James E. Moravek MD**
**Jeremy T. Bell PA-C Sara B. Lennon PA-C Kelly J. Hermann PA-C Cindy M. Spicka APN**

# PATIENT REGISTRATION FORM

All Forms must be completed and signed prior to treatment.

## GENERAL INFORMATION

Patient Name: _____
First Middle Last

Address: _____
Street City State Zip

Home Phone No: _____ Work Phone No: _____

Cell Phone No: _____ Email Address: _____

Date of Birth: _____ Social Security Number: _____ Gender: Male Female
(Circle One)

Race: _____ Ethnicity: _____ Preferred Language: _____

Primary Care Physician: _____ Phone No: _____ City: _____

Referring Physician: _____ Phone No: _____ City: _____

Is this visit for the purpose of: Workman's Compensation Motor Vehicle Accident Personal Injury Self-Pay
(Circle One)

Marital Status: Single Married Widowed Divorced Student: Full time Part time
(Circle One) (Circle One)

Spouse Name: _____

Spouse Date of Birth: _____ Spouse Social Security Number: _____

## PLACE OF EMPLOYEMENT

Name of Patient / Primary Guarantor's Employer: _____ Phone No: _____

Address: _____
Street City State Zip

Name of Spouse / Secondary Guarantor's Employer: _____ Phone No: _____

Address: _____
Street City State Zip

Is this a work related injury? Yes No
(Circle One)

If you answered yes, please fill out the Workman's Compensation Information Form included in the Patient Registration Packet.

## INSURANCE INFORMATION

Name of Primary Insurance Company: _____ Phone No: _____

Mailing Address: _____
Street City State Zip

Policy Holder's Name: _____ ID No: _____ Group No: _____

Relationship to Patient: _____ Date of Birth: _____ Social Security Number: _____

Name of Secondary Insurance Company: _____ Phone No: _____

Mailing Address: _____
Street City State Zip

Policy Holder's Name: _____ ID No: _____ Group No: _____

Relationship to Patient: _____ Date of Birth: _____ Social Security Number: _____

Name:
DOB:
Chart:
Date:

**GUARANTOR INFORMATION** ☐ Check and fill out this section **ONLY IF PATIENT IS A MINOR.**

THIS SECTION MUST BE COMPLETED BY THE **PARENT(S)/GUARDIAN(S)** THAT IS AUTHORIZING TREATMENT

**Primary Guarantor/Parent/Guardian Name:** _____

Address (If different from above): _____
Street City State Zip

Home Phone No: _____ Work Phone #: _____

Relationship to Patient: _____ Date of Birth: _____ Social Security Number: _____

**Secondary Guarantor/Parent/Guardian Name:** _____

Address (If different from above): _____
Street City State Zip

Home Phone No: _____ Work Phone #: _____

Relationship to Patient: _____ Date of Birth: _____ Social Security Number: _____

**PLEASE PROVIDE VALID PICTURE I.D. & PRIVATE INSURANCE CARD.**

## CONSENT TO HEALTH CARE SERVICES

I, the undersigned Patient, or undersigned person responsible for consenting on patient's behalf hereby request and consent to MidAmerica Hand to Shoulder Clinic to be examined and treated by the medical, nursing and other healthcare personnel who may participate in the Patient's care. I hereby acknowledge that all information provided herein is true to the best of my knowledge.

I hereby assign, transfer and set over to MidAmerica Hand to Shoulder Clinic all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I revoke said authorization and give written notice.

I understand that my co-pay, if applicable, is due prior to being seen and if my co-pay is not paid I may have to reschedule my appointment.
I understand that all cancellations of appointments must be made at least 24 hours in advance and rescheduled within the same business week whenever possible, I understand that there will be a $10.00 charge for all appointments cancelled with less than 24 hours notice, unless the appointment is rescheduled. I understand that there will be a $25.00 charge for all appointments missed with no call made cancelling the appointment. I also understand that three consecutive no show appointments may result in a discharge from MidAmerica Hand to Shoulder Clinic.

I hereby agree to pay the regular charges of the physician for any treatment performed on my behalf or authorized by me.
I understand that I am financially responsible for all charges whether or not they are covered by my insurance plan or fall into the insurance company's definition of usual and customary. MidAmerica Hand to Shoulder Clinic is committed to providing the best treatment possible for our patients and our charges are considered usual and customary for our area. I understand that all bills are to be paid in full within 45 days of submission to my insurance company. MidAmerica Hand to Shoulder Clinic does not wait for the settlement of lawsuits. Interest of 11/2% per month up to 9% annually will be charged after 60 days. An authorized, approved payment plan will eliminate interest charges and collections. I understand that I am responsible for all costs of collection for any outstanding fees, including but not limited to any attorney fees, court costs, expenses and interest incurred from the date of my initial consultation with any physician at the MidAmerica Hand to Shoulder Clinic.

_____ _____
Patient / Primary Guarantor / Parent / Guardian Signature Date

_____ _____
Spouse / Secondary Guarantor / Parent / Guardian Signature Date

_____ _____
Private Insurance Policy Holder's Signature Date