

CAROLINA BONE & JOINT, PA

PATIENT AND INSURANCE INFORMATION

Account No. _____

Patient Name _____ Male Female
Last First Middle

Address _____
Number Street City State Zip Code

Home Phone No. (____) ____ - ____ Cellular Phone No. (____) ____ - ____ Pager No. (____) ____ - ____

E-mail Address _____ SSN ____/____/____ Date of Birth ____/____/____

Marital Status _____ Spouse's (or Guardian's) Name _____
(If minor, please give guardian's information)

Patient's (or Guardian's) Employer _____ Phone No. (____) ____ - ____ Ext. ____

Spouse's (or Guardian's) Employer _____ Phone No. (____) ____ - ____ Ext. ____

In Case of Emergency Contact _____ Relationship to Patient _____
someone other than spouse or guardian

Emergency Contact Home Phone No. (____) ____ - ____ and Work Phone No. (____) ____ - ____ Ext. ____

Referred By Doctor Relative/Friend Employer Lawyer Other _____

Name of Person Who Referred You _____ Primary Care Physician _____

Type of Injury or Illness On-the-Job Injury Auto Accident Other Accident Disability Evaluation Illness

Primary Insurance _____ Secondary Insurance _____

Policy No. _____ Policy No. _____

Group No. _____ Group No. _____

Policyholder _____ Male/Female Policyholder _____ Male/Female

Policyholders SSN ____/____/____ DOB: _____ Policyholders SSN ____/____/____ DOB: _____

Employer _____ Employer _____

AUTHORIZATION: If you have a managed care plan we will need prior authorization from your plan or primary care physician for each visit. If authorization is not on file in our office you will need to be rescheduled so that you can obtain the necessary authorization.

PAYMENT POLICY: Some insurance companies pay fixed allowances for certain services and procedures while others pay a percentage of the charge. As a courtesy we will bill your insurance carrier(s), but to help us do so, please allow our staff to copy your insurance card(s). However, it is your responsibility to pay any deductible, co-pay, coinsurance or any other balance not paid by your insurance. If you cannot pay the balance due, please speak with our patient representative to set up a payment plan that meets our mutual financial needs. If any over payment is posted to your account, refund checks are issued on or about the 25th day of each month.

I authorize the release of medical information necessary to process this and all future claims, and authorize payment of insurance benefits to Carolina Bone and Joint, P.A. for all medical services rendered by the physicians and staff of Carolina Bone and Joint, P.A. I understand that I am financially responsible for any deductible, co-pay, coinsurance amount and/or any charges not paid by my insurance plan(s), and any payment currently due must be paid at the time the services are rendered unless other arrangements are made in advance.

X

Signature of patient or legal guardian

_____/_____/_____
Date signed

cbj174 revised 8/02