FREDERICKSBURG ORTHOPAEDIC ASSOCIATES, P.C.

PATIENT INFORMATION SHEET

AP #	Today's Date:	FOA Initials:

PATIENT INFORMATION

Last Name, First Name, MI:	Home Phone:	Cell Phone:	SSN:

Birth Date (MM/DD/YYYY):	Age:	Sex: Male☐ Female☐	Marital Status: ☐Single ☐Separated ☐Married ☐Divorced ☐Widowed

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino	Race: ☐American Indian or Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian ☐White/Caucasian ☐More than one race ☐Other Pacific Islander	Language:

Mailing Address:	City:	State:	Zip:

Physical Address (911 Information):	County / City:

Email Address:	Preferred Notification Method: ☐Postal Mail ☐Phone ☐Web Message	Occupation:
Employer:	**Employer Address:**	**Work Phone:**
Pharmacy:	**Pharmacy Address:**	**Pharmacy Phone Number:**

IF PATIENT IS UNDER 18 OR LIVING WITH PARENT(s)

Father's Full Name:	Father's Address:	Father's SSN:	Father's Phone Number:
Father's Employer:	**Employer Address:**	**Father's DOB:**	**Father's Work Number:**
Mother's Full Name:	**Mother's Address:**	**Mother's SSN:**	**Mother's Phone Number:**
Mother's Employer:	**Employer Address:**	**Mother's DOB:**	**Mother's Work Number:**

SPOUSE'S INFORMATION

Spouse's Full Name:	Spouse's DOB:	Spouse's SSN:
Employer:	**Employer Address:**	**Work Phone:**

INSURANCE INFORMATION

Primary Insurance:	Subscriber:	DOB:	ID#:	Group #:
Is Your Primary Insurance Medicare? ☐ YES ☐ NO		**Primary Care Physician (first & last name):**		
Secondary Insurance:	**Subscriber:**	**DOB:**	**ID#:**	**Group #:**
Tertiary Insurance:	**Subscriber:**	**DOB:**	**ID#:**	**Group #:**

PLEASE READ AND SIGN THE FOLLOWING:

I have read and understand the information listed on the front and back of this form. The information provided by me is correct to the best of my knowledge.

_____ _____

Patient / Guarantor Date

To Our Patients: All professional services rendered are charged to the patient and are due at the time of service unless you have presented verification of insurance coverage for all diagnostic visits and procedures. We will automatically file all charges with your insurance company once you have provided us your complete insurance information. Please remember your insurance coverage is a contract between you and your insurance. We will do everything possible to expedite your claim with proper filing and forms. However, **YOU ARE** responsible for all fees not paid by your insurance.

To Our Patients with HMO Coverage: It is your responsibility to obtain the proper referrals from your PCP. Our HMO contracts state that all patients must have a valid referral prior to their visit. Without this referral you will be asked to reschedule your appointment or to sign a waiver acknowledging no referral and your agreement to pay all charges in full.

To Our Patients with Worker's Compensation / DOL: If you were injured while in the course of your employment, we will file your compensation claim for you once we have verification from your employer that your claim is valid. We will ask for your personal health insurance for future use if needed. You will be responsible for any charges not paid within (90) days by your Worker's Compensation Insurance Carrier. Fredericksburg Orthopaedic Associates, P.C. does not participate with out of state Worker's Compensation.

To Our Patients with Tricare Standard or Tricare for Life: We are not participating with Tricare. Our physicians and physician assistants are authorized Tricare providers. We will file you claim(s) for you. Primary Tricare claims will be filed as Non-Assigned and payment will be sent to the subscriber. Once the patient/guarantor receives payment, please submit all payments and explanation of benefits to our office so proper adjustments to the account can be processed. As authorized providers, any balance over 115% of the Medicare allowed rate will be adjusted from the account balance. The patient/guarantor will be billed for the amount paid by Tricare plus any non-paid balance up to the 115% of the Medicare allowed rate.

To Our Medicare Patients: Medicare requires that all Medicare Patients read and sign the following before we can file your claim(s). I request that payment of authorized Medicare benefits be made on my behalf to Fredericksburg Orthopaedic Associates, P.C. for any services furnished to me by their Physicians or Physician Assistants. I authorize any holder of medical information about me be release it to the Health Care Financing Administration (HFCA) and its agents and to my insurance company, any information needed to determine these benefits or the benefits payable for related services.

ALL PATIENTS: I authorize release of medical information to my insurance carrier(s) and authorize payment directly to Fredericksburg Orthopaedics Associates, P.C. If this account becomes delinquent, I hereby agree to pay 33 1/3% of attorney and/or collection agency costs plus court costs.

_____ _____

Patient / Guarantor Date