COLUMBUS ORTHOPEDIC & SPORTS MEDICINE CLINIC

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4508 38th St., Suite 133 · Columbus, NE 68601

Account # ______________

Name of Patient ____ SEX ____M ___ F

FIRST MI LAST

Patient Address ________________________________City _______________ State ____ Zip ___________

Home Phone ____________________ Work Phone ____________________ Cell Phone ___________________

Birth Date ___/___/___ SSN ______-_______-_______ Marital Status (circle one) S M D W

Race __________________ Ethnicity _________________ Referring Physician __________________________

Retired: Yes / No Disabled: Yes / No Employer ___________________________ Occupation:____________________

Email address ____ (Authorization for patient portal access Yes / No)

Preferred Method of Contact ____Home Phone ____Cell Phone ____Work Phone ____Email ____US Mail

Spouse/Guardian Name ____ Date of Birth ___/___/___

Address if different than patients ______________________________City ______________ State ____ Zip _____

Home Phone __________________ Work Phone __________________ Cell Phone __________________

Email address ____

Retired ____ Employer ___________________________________ Occupation __________________

Person Financially Responsible (If not Patient) ____

Relationship to Patient _______________________ Date of Birth _______________Phone Number ____________________

Address ____________________________________City _______________ State ____ Zip ___________

EMERGENCY CONTACT (RELATIVE, FRIEND, NEIGHBOR)

Name ____ Relationship to Patient __________________

Phone Number _____________________ Address ____

DO YOU HAVE MEDICAL INSURANCE? ___YES _____NO If you have insurance, we will make a copy of your card(s)

Name & Address of **PRIMARY** Insurance____

POLICY HOLDER Name ______________________________SSN ____________________ Date Of Birth: ___________

Do you have a co-pay for office visits? YES ___ NO____ Amount $_________

Name & Address of **SECONDARY** Insurance____

POLICY HOLDER Name ______________________________SSN ____________________ Date Of Birth: ____________

Do you have a co-pay for office visits? YES ___ NO____ Amount $_________

Services are rendered on a CASH BASIS ONLY unless previous arrangements are made.
I/We authorize payment of medical benefits directly to COLUMBUS ORTHOPEDIC & SPORTS MEDICINE CLINIC. I/We also agree that this authorization will be perpetual in nature and a copy of this assignment is as valid as the original. I/We further agree that should my insurance benefits be insufficient to cover the entire amount of charges, I/We will be responsible for the difference. I/We agree that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims, and all proceeds of insurance are assigned to this Clinic where applicable, but without assuming responsibility for the collection thereof. I/We agree that the above information is for the purpose of obtaining credit and is warranted to be true; I/We authorize the Clinic or its agent to make a credit investigation, including employment verification. I/We agree that charges shown by statements are correct and reasonable unless protest within 30 days of original billing date. I/We agree that in the event legal action should be necessary to collect an unpaid balance due for services rendered to me or my family, I/We will pay reasonable attorney's fees or other such costs as the Court determines proper. I/We knowing that I/We have a condition(s) requiring examination, diagnosis, medical and/or surgical treatment, hereby consent to such treatment, including photographs, videotaping, documentation and storage of medical records, in any form. I/We further acknowledge that no guarantees are made as to the results of such treatment. I/We consent to and authorize the release of medical information to my insurance provider and/or physician and/or other health care provider concerning my/our examination, diagnosis and treatment. You are entitled to a copy of this agreement should you request one.
(MEDICARE ONLY: I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF FOR ANY SERVICES FURNISHED ME BY COLUMBUS ORTHOPEDIC & SPORTS MEDICINE CLINIC INCLUDING PHYSICIAN'S SERVICES. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCIAL ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS FOR RELATED SERVICES. WE ARE INFORMING YOU THAT SOME SERVICES MAY NOT BE PAYABLE BY MEDICARE IF THEY DEEM THEM TO BE NON-COVERED. YOU WILL BE RESPONSIBLE FOR PAYMENT OF NON-COVERED SERVICES. PLEASE REFER TO YOUR MEDICARE HANDBOOK FOR FURTHER DETAILS ABOUT NON-COVERED SERVICES.)

Signature ____**Date** ____________