

PATIENT INFORMATION FORM

PATIENT INFORMATION

Name: _____ Sex: M F DOB: _____
SSN: _____ Cell: _____ Home: _____
Email: _____
Address: _____ City: _____ State: _____ Zip: _____
Preferred Communication: Cell Home Email Mail

PHYSICIAN INFORMATION

Primary Care Physician: _____ Phone: _____
Referring Doctor: _____ Phone: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone: _____
Cross Streets: _____ City: _____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ ID/Claim #: _____
Policy Holder: _____ Relationship: Self Spouse Parent Other
Policy Holder DOB: _____ Policy Holder SSN: _____

SECONDARY INSURANCE INFORMATION

Insurance Name: _____ ID/Claim #: _____
Policy Holder: _____ Relationship: Self Spouse Parent Other
Policy Holder DOB: _____ Policy Holder SSN: _____

EMERGENCY CONTACT / NEXT OF KIN

Name: _____ Relationship: _____ Phone: _____

HIPAA — INFORMATION RELEASE AUTHORIZATION

Who may we release information to regarding your treatment and/or billing?

1. Name: _____ Relationship: _____ Phone: _____
2. Name: _____ Relationship: _____ Phone: _____

PAYMENT INFORMATION & AUTHORIZATION

Your insurance company will be billed for covered services. Any unpaid balance is the responsibility of the patient or responsible party. The balance is due if insurance has not paid within 60 days. Please keep patient and insurance information up to date. Ask us about payment plans if needed.

I understand that I am financially responsible for all charges. I authorize payment directly to **Movement Orthopedics, PLLC** of the surgical and/or medical benefits payable to me, not to exceed reasonable and customary charges. I authorize release of medical information necessary to process claims. A copy of this authorization may be used in place of the original.

I have received a copy and understand Movement Orthopedics' Notice of Privacy Practices.

I have received a copy of the Movement Orthopedics Cancellation and No-Show Policy.

Signature: _____ Date: _____