COLLIER SPORTS MEDICINE & ORTHOPAEDIC CENTER

How were you referred to our office? _____

PATIENT INFORMATION: *PLEASE PRINT PATIENT'S LEGAL NAME*

Patient's Name: _____ Sex M F
Last Name First Name Middle Initial

Date of Birth: _____ Social Security #: _____

Street Address: _____

City, State, Zip _____ Email Address: _____

Pharmacy Name/Address /Phone _____

Home Phone #: _____ Cell Phone #: _____

Marital Status: □ Single □ Married □ Other _____
Spouse's Name if Applicable

Are you over 18? □Yes □No If **no**, please provide parent or legal guardian's name and social security #.

Parent/Legal Guardian's Name: _____ Social Security #: _____-

NORTHERN ADDRESS (Address, City, State, Zip): _____

_____

EMERGENCY CONTACT: _____

Relationship: _____ Phone #: _____

EMPLOYER / SCHOOL

Name of Employer/School: _____ Phone #: _____

HEALTH INSURANCE

Note: We will need to make a copy of your insurance cards and driver's license.

Primary Insurance: _____ Policy #: _____

If different from above, please complete.

Policyholder's Name: _____ Date of Birth: _____

Social Security #: _____ Employer: _____

How will you be paying today? □ Cash □ Check □ Credit Card

I hereby authorize any insurance benefits to be paid directly to the physician providing services and recognize my responsibility to pay for all non-covered services. I also authorize the physician to release any information necessary to process an insurance claim.

A parent or guardian who will be responsible for payment of the bill, at the time of service must accompany the child. We cannot be bound by any divorce or other family relationship contracts.

Signature: _____ **Date**: _____

Patient's Name:		D.O.B:
Social Sec. #	Age:	Occupation:

Why are you seeing the doctor today?

_____

Review of Medical History

Please check if you are currently having or have you had problems with any of the following. If yes, describe.

Eyes	☐ No	☐ Yes	_____
Ears, Nose Throat	☐ No	☐ Yes	_____
Lungs/Respiration	☐ No	☐ Yes	_____
High Blood Pressure	☐ No	☐ Yes	_____
Heart Disease	☐ No	☐ Yes	_____
Diabetes	☐ No	☐ Yes	_____
Digestion/Gastrointestinal	☐ No	☐ Yes	_____
Numbness/Tingling	☐ No	☐ Yes	_____
Skin Disease	☐ No	☐ Yes	_____
Cancer	☐ No	☐ Yes	_____
Arthritis	☐ No	☐ Yes	_____
Allergies	☐ No	☐ Yes	_____
Drug Allergies	☐ **No**	☐ **Yes**	_____

Who is your medical doctor? _____Phone#: _____

Please list any medications are you currently taking: _____

_____

When was your last flu shot? _____ When was your last pneumonia vaccine? _____

What is your height? _____ _ What is your weight?_____

Past Medical/Family/Social History

Surgeries/Hospitalizations/Illnesses Year Surgeries/Hospitalizations/Illnesses Year

_____

_____

Family Member	Age	Alive	Deceased	Health status or Cause of death
Father	____	☐	☐	_____
Mother	____	☐	☐	_____

Do you smoke? ☐ No ☐ Yes If yes, packs per day? _____ For how many years? _____

Patient's Signature:	Date:
Reviewed By: M.D.	Date:

FINANCIAL POLICY

James J. Guerra, MD, FACS

Please review our financial policy and direct any questions or concerns to our billing manage•·.

Medicare

This office accepts Medicare assignment. The Federal Government regulates all Medicare fees. You will be responsible for all deductibles and co-payments. Tn addition, you are responsible for all services not covered by Medicare, such as unrelated office visits in the global period, charges for the surgical assistant for surgery and any injections or injectable medications. Please note that Medicare does NOT cover medical supplies. You are directly responsible for payments of supply charges to the office. Our office files secondary insurance after Medicare payment. However, if we do not receive payment from your secondary carrier within 30 days, the balance will be your responsibility.

PPO Plans/Private Insurance

Each patient is responsible for his/her medical bills, and coinsurance and deductibles are due at the time of your appointment. As a courtesy to you, we will file your insurance claim. All deductibles, co-payments, and differences between your insurance carrier's reimbursement and our fee schedule are the responsibility of the patient. In addition , patients will be responsible for all non-covered services or supplies such as fiberglass or injectable medications. We will be pleased to assist you in appealing to your insurance carrier if there is a large discrepancy between your bill and your benefits. If you are scheduled for surgery, we will contact your insurance company to obtain pre-certification and verify coverage to determine patient responsibility. The determined amount will be due at your pre-operative visit.

Worker's Compensation/Liability/Motor Vehicle Accident

Worker's compensation patients are required to present a notice of injury before they can be seen. We do not accept letters of protection as a form of payment in litigation disputes. In such cases, patients are completely responsible for payment at the tune service is rendered. An assignment of benefits form requiring a signature is required before being seen for all motor vehicle accident patients.

Ancillary Medical Services

When your medical care requires a separate surgical facility, pathology, laboratory studies, or radiological examination you will receive a separate bill from the facility rendering the service. This office refers to the ancillary service facilities that we believe provides the best medical care for you. It is the responsibility of the patient to make sure that precertification has been obtained if necessary.

Payment Plans/Collections

Each patient accepts full and total responsibility for payment of any services rendered through this office. While we are pleased to assist you in filing with your insurance agency, your contract with your insurance agency is completely separate from your responsibility to this office. All past due accounts will be subject to a 1.5 monthly service charge. After 90 days, accounts are turned over to Gulf Coast Collection Agency or pursued by an attorney unless other arrangements are made with the billing manager. Patients will be responsible for attorney's fees and collection costs .

I understand my responsibility for services rendered by Collier Sports Medicine and Orthopaedic Center.

_____

Patient /Guarantor Signature Date:

Acknowledgment of Receipt of Notice of Privacy Practices

Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's Notice of Privacy Practices in the reception area. You are not required to read this Notice, however, we would like your acknowledgment that you have been notified that the practice has such a Notice of Privacy Practices. Your signature below signifies your understanding and opportunity to ask questions.

_____

Patient/Guarantor Signature Date:

Collier Sports Medicine and Orthopaedic Center, P.A. Accident/Injury Form

Dear Patient/Guarantor,

Your insurance contract provides for benefits to be coordinated with other medical insurance by which you may be covered. The primary carrier pays first when there is more than one insurance company. In order for us to expedite your claim process, the following information **must be completed.** If the reason for your visit is not a result of an accident or injury, please state so.

Patient's Name:	Date of visit:
Insurance I.D.#:	Group#:

ACCIDENT OR INJURY DETAILS

Is the reason for your visit a result of an accident? ☐ **Yes** ☐ **No**

Date of accident or injury:_____

Please check if the accident/injury is related to any of the following:

☐ Work ☐ Auto ☐ Sports/School ☐ Home ☐ Other: _____

Did this accident/injury occur while: (check all that apply)

☐ Lifting ☐ Pulling ☐ Pushing ☐ Twisting ☐ Falling

☐ Bending ☐ Reaching ☐ Squatting ☐ Hit by object

How did this accident occur?

_____

Where did the accident/injury occur?

I have completed this questionnaire and carefully reviewed its contents. I attest to the accuracy and correctness of the information. Unanswered questions indicate they do not apply.

Patient/Guardian Signature: _____ Date: _____