McKinley
Orthopedics, Sports Medicine & Spine

First Name: _____Last: _____ MI: _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

SSN: _____ Birthdate: _____ Sex: Male Female

Home: _____Cell: _____OK to leave message? _____

If minor, legal guardian name: _____ Birthdate: _____

Race: _____ Ethnicity _____Preferred Language: _____

Primary/Referring Doctor Name and Number: _____

Person(s) allowed to receive my medical information: _____

Employer Name: _____ Phone: _____

**EMERGENCY CONTACT**

Contact Name: _____Relation to patient: _____

Contact phone: _____

## INSURANCE & BILLING INFORMATION

1. **Primary Insurance Company**: _____ ID#: _____

Policy Holder's name: _____ Group Number: _____

Birthdate: _____ SSN: _____ Relationship to Patient: _____

2. **Secondary Insurance Company**: _____ ID#: _____

Policy Holder's Name: _____ Group Number: _____

Birthdate: _____ SSN: _____ Relationship to Patient: _____

**IS THIS A WORKERS COMP CLAIM**: Y N

Insurance Name: _____ Date of Injury: _____

Claim#: _____ Adjuster Name and Number: _____

**CONTINUED ON THE BACK**

# FINANCIAL POLICY

**We recommend that you research your insurance benefits and eligibility.**

- Insurance coverage is not a guarantee of payment.

- I understand that McKinley Orthopedic and Sports Medicine is not "In-network" with all insurance companies. We are in network with Aetna/BlueCross/Medicare/Medicaid/VA/Tricare/Workers Comp/Auto. We do not get involved with attorney or third-party liability issues. I understand that I am responsible for services provided due to Auto accident if complications arise with the insurance not paying the claims.
- I understand that copays, coinsurance, deductibles, patient balances and/or noncovered services/supplies are due at the time of service unless prior arrangements are made with the billing office.
- We will bill your insurance based on the information you provide us. You are responsible to inform our office of any changes/updates to your insurance information. If claims deny due to inaccurate information this will become patient responsibility.
- You are ultimately responsible for payment of services rendered. If we do not hear from the insurance within 60 days of submission the balance will become patient responsibility.
- After claims process through insurance patient will receive a statement(s) and payment is due at that time. If payment has not been received within 60 days your account may be sent to a collection agency. In the event your account is sent to collections this may result in discharge from care.
- I hereby authorize McKinley Orthopedic and Sports Medicine to release my information to my insurance company and my insurance company to release information to McKinley Orthopedic and Sports Medicine. I hereby assign benefits to be paid directly to McKinley Orthopedic and Sports Medicine for this date and any future visits I may have.

By signing below, I acknowledge I have read and understand the above and I accept responsibility to pay for all services rendered which my insurance does not cover.

_____ _____

Patient Signature (Responsible Party) Date

_____ _____

Printed Name Relationship to Patient

Patient/Guardian E-mail address: _____

## EMAIL CONSENT

McKinley Orthopedic and Sports Medicine offers you the ability to communicate with us via email. However, due to HIPPA regulations we need the consent from you before we are able to send or receive any emails including but not limited to chart notes, ledgers, receipts, appointments, intake and history information, imaging/lab results, etc**. (if you would like to exclude any individual item from consent please cross through and initial)**

By signing below, I understand, most email services (Hotmail, Gmail, Yahoo) do not utilize encrypted email and McKinley Orthopedic and Sports Medicine is not liable. I give my consent to communicate by email with McKinley Orthopedic and Sports Medicine.
**(Leave blank if you do not wish to ever correspond via email)**

_____ _____ _____

Signature Date Printed name