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11600 Busy Street, Richmond, VA 23236 • 804-440-HURT (4878) • FAX-804-423-2451

PATIENT REGISTRATION

For Office Use Only	
GE Id # _____	MR # _____

PATIENT NAME _____ Sex M F **D.O.B.** _____ **SS #** _____

Marital Status: Single Married Divorced

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Email _____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

NAME OF RESPONSIBLE PARTY _____ **D.O.B.** _____ **SS #** _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____

Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT _____ **Phone #** _____

Relationship to Patient _____

PRIMARY CARE PHYSICIAN _____ **Office Phone #** _____

Impairments: Vision Hearing Mobility Other _____ N/A Primary Language _____

How were you referred to Advanced Orthopaedic Centers?

Primary Care/Other Physician _____ Family/Friend _____

White/Yellow Pages WebSite Newspaper TV Radio Direct Mail Self

HEALTH INSURANCE COVERAGE

To be completed by ALL patients.

(In the case of workers' compensation, this information will only be used if your case is denied.)

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company Name		
Policy Holder's Name		
Policy Holder's Date of Birth		
Policy Holder's SS #		
Relationship to Patient		
Policy Holder's Employer		

WORKER'S COMPENSATION

Please complete this section if your illness/injury is work related.

Date of Injury _____ Claim # _____

Employer's Name _____

Employer's Address _____

Contact Person _____ Employer's Telephone # _____

PATIENT AUTHORIZATION FOR TREATMENT, CLAIMS & PAYMENT

Thank you for selecting Advanced Orthopaedic Centers (AOC) or its affiliates as your health care provider. We are committed to providing you with the best possible medical care. Following is an authorization for treatment, claims payment and review of policies which we require you to sign prior to any treatment.

Authorization for Medical Treatment: I authorize and consent to health care services or supplies including, but not limited to, diagnostic procedures, injections, therapy and medical treatment at and by AOC or its affiliates. I acknowledge that no guarantees or promises have been made to me as to the result to be obtained from such services. I have the right to refuse treatment and/or medicines after my physician has given me adequate explanation.

Financial Agreement: In consideration of health care services provided to me by AOC or its affiliates for this and all subsequent services, I agree to pay AOC in accordance with its regular rates and terms of payment. I assume full responsibility for payment of all charges associated with the health care services provided to me, including any portion not paid by insurance carriers, worker's compensation or any third party. Such unpaid charges may include, but are not limited to, co-payment, deductible, coinsurance amounts and/or services considered by my carrier to be non-covered. Should my account be referred for collection, I agree to pay all collection costs and expenses, including attorney's fees. As required by your insurance carrier, you are responsible for obtaining any necessary referral or authorization if your insurance policy mandates such paperwork. You will need to present a completed referral at the time of your appointment. You are required to pay any mandatory co-payment at the time of service.

Medicare Lifetime Signature Agreement (if applicable): I authorize any holder of medical or other information about me and their agents to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and I request payment under Medicare be made to the physician, provider or other supplier of services or supplies furnished by the physician, provider or other supplier.

Assignment of Benefits: In consideration of healthcare services provided to me by AOC or its affiliates for this and all subsequent services, I hereby assign to AOC any and all rights, benefits and claims I may have under any policy of insurance (major medical, automobile, liability, worker's compensation and any other) and the proceeds from any claim that I may have for injuries. I permit a copy of this authorization and assignment to be used in place of the original. Such assignment hereby authorizes direct payment to AOC under and/or from any such policy of insurance or proceeds.

For your convenience, we accept cash, checks or Visa/MasterCard/Discover. Debit cards are also accepted at all locations. All patient checks are processed through an Electronic Clearing House.

I understand that my AOC physician may refer me to another facility or entity for health-related services, appliances or devices, and that the physician may have a financial or ownership interest in that facility or entity. I have been advised that AOC physicians have, or may have, a financial or ownership interest in: AOC's surgical and therapy departments; Ortho On-Call; and the MRI service located at Virginia Physicians, Inc. I further understand that such health-related services, appliances or devices may be available from other suppliers in the community and that I have the freedom to choose the facility or entity that I want to use.

I understand that family members, case managers or others will be allowed in the examination room at the discretion of the treating physician.

I understand that AOC may access the Virginia Prescription Monitoring Program (PMP) without specific patient consent.

Patient's Signature

Date

Signature of Legal Guardian or Power of Attorney

Date

Signature of Financially Responsible Party (if different from above)

Date

Witnessed by AOC Representative

Date