7858 Shrader Road • Richmond, VA 23294 • 804-270-1305 • FAX-804-273-9294
13700 St. Francis Boulevard, Suite 605 • Midlothian, VA 23114 • 804-320-4048 • FAX-804-423-8489
11600 Busy Street, Richmond, VA 23236 • 804-440-HURT (4878) • FAX-804-423-2451
8901 D Three Chopt Road, Richmond, VA 23229 • 804-440-HURT • 804-888-7733

PATIENT REGISTRATION

For Office Use Only
GE Id #__________________ **MR #**______________________

PATIENT NAME ________________________________ **Sex** ☐ M ☐ F **D.O.B.** ____________ **SS #** ________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

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 ID #		
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 #___________________________

(OVER)

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**