East Alabama Orthopaedics & Sports Medicine, LLC

Account #: _____ Date: _____

PATIENT INFORMATION

SSN: _____ Birthdate: _____ Sex: _____ Marital Status: _____

Last Name: _____First: _____ Middle: _____ Preferred Name: _____

Address: _____

City: _____State: _____ Zip: _____ Phone: (_____)_____ Cell: (_____)_____

Primary Physician: _____ Referring Physician: _____

Employment Status: Full-Time Part-Time Self-Employed Activity Duty Retired Not Employed Student

Employer: _____ Phone: (_____)_____X-_____

Person Responsible for Account: _____

Address: _____

City: _____State: _____ Zip: _____ Phone: (_____)_____

Person to notify in case of emergency: _____Phone: (_____) _____

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARDS AND DRIVERS LICENSE

Insurance Company (Primary): _____

Policy Holder's Name: _____ Birth date: _____ Relationship: _____

Employer: _____

Contract Number: _____ Group Plan Number: _____

Insurance Company (Secondary): _____

Policy Holder's Name: _____ Birth date: _____ Relationship: _____

Employer: _____

Contract Number: _____ Group Plan Number: _____

AGREEMENT TO PAY

In consideration of medical services rendered, the undersigned accepts all fees charged as lawful debt and agrees to pay EAOSM (East Alabama Orthopaedics & Sports Medicine) insurance notwithstanding, for all said charges. Furthermore, undersigned agrees ton pay the costs of collections including reasonable attorney's fees, and court cost if such be necessary, waiving now and forever the right of exemption allowed to the constitution and the laws of the State of Alabama or any other state. Undersigned further understands that EAOSM does not accept insurance assignment as a guarantee of full payment.

Assignment of Insurance Benefits and Release of Information

My signature below authorizes my insurance company to mail payment of authorized benefits for any medical services rendered directly to EAOSM. Furthermore, my signature below authorizes EAOSM to release my insurance company medical information regarding his treatment for the purpose of determining eligibility for and payment of charges for services rendered in connection with his care.

Health Insurance Portability and Accountability Act (HIPAA)

I consent to use or disclosure of my protected health information (PHI) by EAOSM (the Company) for the purpose of diagnosing or providing treatment to me, obtaining payment for health care bills or to conduct health care operations.

SIGNATURE: _____ DATE: _____