Comprehensive Orthopaedics, S.C.
6308-8th Avenue, Suite 505
Kenosha, WI 53143

PATIENT NAME________________________________ **PATIENT D.O.B.**__________________
LAST FIRST MI

COMPLETE ADDRESS____
STREET CITY STATE ZIP

EMPLOYER NAME:__________________TELEPHONE (HOME)______________(DAYTIME/WORK)____________

SEX: M F AGE_____ MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED **PATIENT SSN**__________________

PRIMARY CARE PHYSICIAN__________________REFERRING PHYSICIAN__________________

EMERGENCY CONTACT______________PHONE__________________RELATIONSHIP____________

PARENT ACCOMPANYING CHILD (if patient is a minor)__________________**SSN**__________**D.O.B.**______

COMPLETE ADDRESS____
STREET CITY STATE ZIP

EMPLOYER NAME:__________________TELEPHONE (HOME)______________(DAYTIME/WORK)____________

SPOUSE (if applicable)____

Child(ren) live with: Both Parents Mother/Guardian Father/Guardian Other:______________

PRIMARY INSURANCE INFORMATION

SUBSCRIBER'S NAME________________________**SSN**______________**D.O.B.**__________

COMPLETE ADDRESS____
STREET CITY STATE ZIP

RELATIONSHIP TO PATIENT______________________PHONE______________________

EMPLOYER______________ADDRESS:____________________________PHONE______________
STREET CITY STATE ZIP

INSURANCE CO.__________________INSURANCE ID#______________GROUP #______________

EFFECTIVE DATE__________________________

SECONDARY INSURANCE INFORMATION

SUBSCRIBER'S NAME________________________**SSN**______________**D.O.B.**__________

COMPLETE ADDRESS____
STREET CITY STATE ZIP

RELATIONSHIP TO PATIENT______________________PHONE______________________

EMPLOYER______________ADDRESS:____________________________PHONE______________
STREET CITY STATE ZIP

INSURANCE CO.__________________INSURANCE ID#______________GROUP #______________

EFFECTIVE DATE__________________________

IF YOU ARE HERE FOR A WORK REALTED INJURY

DATE OF INJURY__________TYPE OF INJURY____________________________

EMPLOYER________________CONTACT (if known)______________________

ADDRESS ____________________________PHONE__________________

FOR OFFICE USE ONLY ***INS CO.:*** ________________________ ***PHONE:***__________

CONTACT PERSON:____________________***CLAIM#:***__________

Updated 6/14/2007 elp

Comprehensive Orthopaedics, S.C.

AUTHORIZATION TO RELEASE AND ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY

Please read carefully and sign below.

I, ____, request payment of authorized Medicare/Other Insurance Company benefits be made on my behalf to *Comprehensive Orthopaedics, S.C.,* for any services furnished to me. Regulations applicable to Medicare assignment of benefits apply.

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for any amount deemed by the insurance carrier to be beyond their "usual, customary and responsible" charges as well as for any amounts applied to deductible, insurance co-payments, or non covered services.

I hereby authorize Comprehensive Orthopaedics, S.C. to release to the Social Security Administration and Health Care financing Administration or its intermediaries, or insurance carriers, and medical information needed for this or a related Medicare/Other Insurance Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits be assigned to the Physician in charge of my care. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

*This authorization is in effect until I choose to revoke it.

Insurance Coverage Waiver
I understand that my eligibility for coverage by ____(name of Insurance Co,) cannot be confirmed at this time. I wish to receive medical service from Comprehensive Orthopaedics, S.C. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Charges for copying Medical Records: In accordance with the State of Wisconsin Regulations and Statutes, there may be a charge for copying medical records. The charge varies on a case by case basis and is dependent on a number of factors. If you would like to know the charge ahead of time we can pre-bill you, however this will delay your records an additional week and they will not be released until payment is made in full.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices, which explains how my health insurance information will be handled in various situations. **My signature below indicates I have provided accurate information to the best of my knowledge and I understand and agree to the provisions above.**

FINANCIAL POLICY

I have received and read the Comprehensive Orthopaedics, S.C. Financial Policy and agree with its terms and provisions. **I understand I am responsible for all Comprehensive Orthopaedics, SC charges regardless of my insurance status. In the event I "no show" for my appointment without calling the office in advance, I understand I will be charged $50.00. In the event Comprehensive Orthopaedics, SC requires legal action to collect payment from me, I understand and agree that I will be responsible for all court costs and attorney fees.**

Please sign below to verify that you have read all above information and agree to the terms.

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***Patient/Guardian Signature** **Date**

IF PATIENT IS A MINOR, PLEASE ALSO SIGN THE FOLLOWING SECTION:

I hereby authorize Dr. Shapiro, Dr. Seipel, Dr. Main, Dr. Vashi, Dr. Didinsky & Dr. Gershtenson or their designated clinicians to administer treatment as deemed necessary.

In divorce situations, the accompanying parent is responsible for the payment of charges, regardless of the divorce decree. Comprehensive Orthopaedics, S.C. is not a party to your divorce and if payment issues exist they must be resolved between parents.

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***Patient/Guardian Signature** **Date**

RESERVED FOR OFFICE USE
WITNESS INITIALS:________