SAN DIEGO ORTHOPAEDIC ASSOCIATES MEDICAL GROUP, INC. sdoa

REGISTRATION

Doctor _____
Account #_____

Patient Last Name_____ First Name_____ Initial _____ Date _____

Birth Date _____ Age _____ Sex ☐ M ☐ F Social Security#_____ Driver's License#_____

Street Address_____ City _____State _____ Zip_____

Home Phone_____ Work/Mobile_____ Email _____ Body Part_____

How &Where Injury Occurred_____

Date of Injury_____ How did you learn about our office?_____

Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury for which someone else might be legally liable? ☐ Yes ☐ No Your Initials:

PATIENT'S EMPLOYER	Company Name_____ Occupation_____ Address_____ City_____ State_____ Zip_____
PATIENT'S PRIMARY INSURANCE	Insurance Company _____ ☐ PPO ☐ HMO ☐ POS **COPAY**_____ Policy _____ Group # _____ Effective Date _____ Insurance Address_____ Phone_____ Name of Insured _____ Relationship to patient _____ Birth Date _____ SSN _____ Employer_____
ADDITIONAL INSURANCE COVERAGE	Insurance Company _____ ☐ PPO ☐ HMO ☐ POS **COPAY**_____ Policy _____ Group # _____ Effective Date _____ Insurance Address_____ Phone_____ Name of Insured _____ Relationship to patient _____ Birth Date _____ SSN _____ Employer_____
MEDICAL/ EMERGENCY CONTACT	Referring Physician_____ Phone_____ Address_____ City_____ State_____ Zip_____ Person to contact in emergency: Name_____ Phone_____
PATIENT AGREEMENT	**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned health plan, and hereby assign and convey directly to San Diego Orthopaedic Assoc. Medical Group, Inc. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. I acknowledge receipt of San Diego Orthopaedic Assoc. Medical Group, Inc. Notice of Privacy Practices. _____ Signature of Insured / Guardian _____ _____ Print Name Date

4060 4th Avenue, Suite 700 San Diego, CA 92103 (619)299-8500 Fax (619)297-1443

sdoa ORTHOPAEDIC

WORK, SPORT, RECREATION, LIFE INJURY SPECIALISTS

San Diego Orthopaedic Associates Medical Group, Inc.

PATIENT FINANCIAL POLICY

(Please read carefully)

Welcome to our practice and thank you for choosing us as your health care provider. In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care. If you have any questions regarding this policy please discuss them with our billing department.

General Payment Policies

- Full payment or accurate insurance information is due at time of service.
- Patients are required to present a current insurance card with every visit; without an insurance card you may be required to pay at the time of service.
- We accept cash, check or credit cards (MasterCard, Visa & Discover).
- Cash pay patients must pay in full at the time of service or prior to date of procedure.
- Co-payments are due at time of service. Patients without co-payment at time of service will be required to reschedule appointment or pay a $25.00 administrative fee.
- There will be a $30.00 charge for all checks returned as "NSF" (non-sufficient funds).

Payment of bill is expected upon receipt of our statement. Accounts become past due after thirty (30) days unless alternative arrangements have been previously made through the billing office.

Contract Medicine Payment Policies

All patients are expected to pay any required co-payments at the time of service. For medical services covered under your insurance contract, no additional payments are required. However, patients will be required to pay for non-covered supplies, equipment and services.

Medicare

San Diego Orthopaedic Associates Medical Group does accept Medicare assignment. All patients without a secondary insurance will be responsible to pay the remaining balance after Medicare payment. All patients are responsible to pay for "non-covered" services. Patients may be required to sign an Advance Beneficiary Notice to acknowledge notification of potential non-covered services.

Insurance Billing Information

Your insurance policy is a contract between you and your insurance company. We will, however, do a courtesy billing on your behalf. If your insurance company has not paid your account in full within ninety (90) days the balance may be automatically transferred to your responsibility for payment upon receipt of statement.

Minor Patients

A minor may not be bound by a financial agreement. The parents or guardians accompanying a minor are responsible for full payment. Non-emergency treatment will be denied for unaccompanied minors.

I have read and understand this financial policy and agree to be bound by its terms. I also understand that such terms may be amended from time to time by San Diego Orthopaedic Associates Medical Group, Inc.

_____ _____

Signature of Patient/Parent/Guardian Date

_____ _____

Print Name of Patient