South Palm Orthopedics

REGISTRATION FORM

Patient Information:

Patient Name: _____ _____ _____
(Last) (First) (Middle)

Patient Address: _____

Home Phone: _____ **Cell Phone:** _____ **Primary Care Physician:** _____

Date of Birth: _____ **Male □ Female □** **Date of Injury:** _____

Reason for Injury: _____ **Email Address:** _____

Parent/Guardian: _____ _____ _____
(Last) (First) (Middle)

Insurance:

1. **In the capacity provided for below, I agree to provide to SPO the patient's insurance card and hereby authorize SPO to make a copy of it.**
2. **I understand that certain steps may have to be met before the patient's insurance is required to pay benefits. I am responsible for fulfilling those conditions prior to treatment. It is my responsibility to call the patient's insurance company to get its approval for the provision of services to the patient prior to the time the patient is provided treatment. It is not SPO's responsibility to obtain this prior approval.**
3. **The insurance will only pay for certain services that it deems medically necessary covered services as more particularly described in the agreement with the insurance. If the patient's insurance decides that a service provided by SPO is not a covered service, or that a service provided by SPO, even though it may be a covered service, is not otherwise medically necessary, it will deny payment for that service. In such event, I agree to be personally and fully responsible for paying for such services for which the insurance is not liable or for which the insurance deems the service a Patient responsibility.**

Assignment of Insurance Benefits:

In the capacity provided for below, I want patient's insurance to pay SPO first, before paying any other provider of health care services. I authorize the patient's insurance to pay these benefits (including, without limitation, liability insurance) directly to SPO.

Guarantee of Payment:

1. **I understand that the Patient's medical bills are my responsibility, irrespective of any agreements that I may have with other individuals including, without limitation, insurance carriers, attorneys 3rd party payors, or (in the event of a divorce, separation, or other agreement) my child's parent.**
2. **I agree to pay all these charges or to cause another payor to pay such charges, as the case may be, at the time of service or when I receive the bill(s) unless I make another arrangement in writing with SPO.**
3. **I acknowledge that the patient's medical bills are my responsibility, whether or not I receive a bill or invoice. If, for whatever reason, SPO cannot collect payment from the patient's insurance or from me, then, in addition to the medical bills, I will be responsible to pay for any of SPO's costs of collection including, without limitation, attorney's fees, interest at the maximum allowable rate (currently 1.5% per month), and all costs attributable to the collection of the patient's debt to SPO.**
4. **The name of and contact information for the patient's attorney is recorded below. If the patient does not have an attorney at this time, but hires one in the future. I understand that I am required to advise SPO immediately of the attorney's information to the extent that the services rendered by SPO are attributable to injuries, which will be the subject of a case handled by said attorney.**

Statement of Truthfulness:

I HAVE PROVIDED INFORMATION TO SPO ABOUT THE PATIENT'S INSURANCE AND OTHER AVAILABLE SOURCES OF PAYMENT. THIS INFORMATION IS TRUE AND CORRECT. I UNDERSTAND AND AGREE THAT IF ANY OF THE INFORMATION IS NOT TRUE OR CORRECT, THEN I MAY BE LIABLE FOR DAMAGES AND PENALTIES UNDER THIS AGREEMENT AND FLORIDA LAW.

I certify that I have read and understand this consent. I have signed this consent (check one).
○ As a parent consenting for the minor Patient. ○ As an adult consenting for myself ○ As a legal guardian of the Patient

_____ _____ _____
Please print full name **Patient's Signature** **Date**

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