



GO ORTHOPEDICS

PATIENT REGISTRATION MEDICAL RELEASE BENEFITS ASSIGNMENT

(804) 452-1635 Fax (804) 452-1638 Tax ID 20-1932109

Patient's Name (First, Middle, Initial, Last)				Patient Account Number	Date of First Visit
Street Address				Social Security Number	Home Phone Number
City		State	Zip Code	Email Address	Cell Phone Number
Date of Birth	Age	Sex	Marital Status	Occupation	Work Phone Number
Employer's Name and Street Address				City	State Zip Code
Name of Spouse or Next of Kin (First, Middle Initial, Last)			Relationship	Spouse Employer Name	Spouse Work Phone Number
Spouse Employer Street Address				City	State Zip Code
Responsible Party's Name (First, Middle Initial, Last)				Relationship	Home Phone Number
Responsible Party's Street Address				City	State Zip Code
Is Illness or Injury Work-Related If Yes, List the name of the Person at your Employer Who Should Receive Worker's Comp info					Date of Injury
If an Accident, We Must Have the Following:		Date and Time of Accident		Date and Time You First Saw a Physician	
What is the Name of the Physician Who Referred You to Goradia Orthopedics?				What is the Name of Your Primary Care Physician?	

INSURANCE INFORMATION

Primary Insurance Company Name		Policy Number	Group Number
Primary Insurance Company Address		City	State Zip Code
Subscriber Name		Relationship	
Secondary Insurance Company Name		Policy Number	Group Number
Secondary Insurance Company Address		City	State Zip Code
Subscriber Name		Relationship	

PAYMENT INFORMATION

Your Insurance company will be billed for covered services, and any unpaid balance will be the responsibility of the patient or responsible party. Parents or guardians are responsible for payment with regard to a minor. **The balance of the account will be due and payable if the insurance company has not paid within 45 days or if Workers' Compensation has not paid within 60 days.**

AUTHORIZATION TO RELEASE INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS

I authorize payment directly to Goradia Orthopaedics, PLLC of benefits otherwise payable to me. Also, by my signature and copies thereof, I hereby authorize Goradia Orthopaedics, PLLC to render medical services to me/my minor child and to release any information regarding my medical history, diagnosis, and treatment of me (or child) to my insurance company regarding my claim. I understand that I am financially responsible for all the charges arising for the treatment of the above named patient. If my account is turned over to an attorney or collection agency for collection, I will be responsible for all additional fees, which are usually 33% of the unpaid balance, and all court costs incurred.

I also understand that I am responsible for any fees incurred for transferring my medical records.

I HAVE RECEIVED A COPY OF THE PRACTICE'S OFFICE POLICIES WHICH I UNDERSTAND AND AGREE TO.

I HAVE READ AND UNDERSTAND THE ABOVE. SIGNATURE _____ DATE _____