



# Makefield Orthopaedics, PC

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## PATIENT INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ M/F \_\_\_\_\_ Marital Status: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_

Insurance Information: \_\_\_\_\_

Subscriber: \_\_\_\_\_

Subscriber's Social Security #: \_\_\_\_\_ Subscriber's D.O.B. \_\_\_\_\_

Employer: \_\_\_\_\_

Is claim due to:     Worker's Compensation     Motor Vehicle Accident

## FINANCIAL RESPONSIBILITY

I understand that the physician's billing staff will file all claims for services rendered to my insurance carrier. I, however, acknowledge that I am responsible for any balances that may be due to the physician because of:

- |                                   |  |
|-----------------------------------|--|
| 1. co-insurance or co-pay amounts | 7. denied worker's compensation claim                      |
| 2. yearly deductible amounts      | 8. no insurance coverage                                   |
| 3. non-covered services           | 9. no referral obtained from primary physician             |
| 4. out of network charges         | 10. failure to respond to insurance carrier correspondence |
| 5. terminated coverage            | 11. failure to respond to coordination benefits inquiry    |
| 6. exhausted auto benefits        |  |

I understand that I will receive a statement for any balance due, after my carrier has processed the claim. I understand and am agreeable that the balance of my statement will be paid in full to the physician within 30 days.

If I am unable to pay the entire amount (applies to amounts of \$150.00 or more), I am responsible to immediately on receipt of statement, call the billing office at 800-322-4606 to arrange a monthly payment plan for no less than \$30.00 per month.

I understand that failure to pay my balance or arrange payments and follow that payment agreement may result in collection agency action.

\_\_\_\_\_  
Signature of patient/responsible party

\_\_\_\_\_  
Date