SOUTHLAND
— ORTHOPAEDICS —

20060 Governors Drive, Suite 300, Olympia Fields, IL 60461 | 10, Orland Square Drive, Orland Park, Il 60602
www.southlandorthopaedics.com | 708-283-2600

PATIENT REGISTRATION FORM

PATIENT NAME:

Last Name: ________________ First Name: ____________________ MI: _______________

Gender: F☐ M☐ DOB: __________________

Marital Status: Single☐ Married☐ Divorced☐ Widow/Er ☐

Address: ______________________________________ City: ______________________

State: ____________________________________ Zip code: _____________________

Cell Number: ____________________________ Home Number: ______________________

Email: ____ Social Security: ________________

Race: Declined☐ White ☐ Black/African American☐ Hispanic☐ Asian☐ Other☐

Ethnicity: Hispanic☐ non-Hispanic☐ Decline ☐ **Language:** English☐ Spanish☐ Other☐

Patient Employer: ________________________

Address:____ Phone: ________________

Person Responsible for Bill: _____________________________________ DOB: __________

Address if different than Patient: ____

Pharmacy Name: Pharmacy Name: __________________________________

Address: ______________________City: _______________ State: ______ Zip code: ________

Permission to view Prescription History from External Sources: ☐Yes ☐No

Primary Care Physician: ___________________________ **Referred by:** ________________

Emergency Contact Name

Contact Name: ___________________________________ Relationship: ________________

Contact Number: _________________________________ Address: ___________________

PRIMARY INSURANCE:

Name of Company: __________________________ Subscriber Name: ____________________

Subscriber DOB: ____________________________ Relationship: _______________________

Policy Number: ____________________________ Group Number: ______________________

SECONDARY INSURANCE:

Name of Company: ____________________ Subscriber Name: ___________________________

Subscriber DOB: _____________________ Relationship: ______________________________

Policy Number: ______________________ Group Number: _____________________________

☐I acknowledge receipt of notice of privacy practices (HIPAA) is on the above website and copy of it for the review is available upon request.

☐I authorize Southland Orthopaedics to release information regarding services rendered and allow a photocopy of my signature to be used to file insurance.

☐I authorize and direct my insurer to issue payment for services directly to Southland Orthopedic Ltd. If my insurance is MEDICARE, I request the payment of authorized MEDICARE benefits, for any services furnished to me, to be made on my behalf, to Southland Orthopedic Ltd.

☐In the event of non-payment, I understand that I am responsible for collection, attorney, and court costs.

☐ I authorize any holder of medical information about me to release to the HEALTHCARE FINANCING ADMINISTRATION and its agents any information needed to determine those benefits payable for related services.

FAILURE TO PROVIDE SECONDARY INSURANCE INFORMATION PRIOR TO VISITS WILL RESULT IN PATIENT BEING RESPONSIBLE FOR BALANCE ON ACCOUNT.

Signature: _______________________________ **Date:** ________________________

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NEW PATIENT MEDICAL FORM

NAME: ______________________________**D.O. B:** __________________**DATE:** ________________

Reason for the Visit Today ☐ RIGHT ☐LEFT ____

Summary of your PAIN/ISSUE ____

Is It Auto Accident Related? ☐ No ☐Yes. If yes, please complete Auto Accident Form.

Is this Work Related? ☐ No ☐Yes. If yes, please complete Workers Compensation Form.

Pain Level (circle): 1 2 3 4 5 6 7 8 9 10

Height: __________inch **Weight:** __________ lbs.

Please list any RECENT, X-Rays, MRI's, CT scans done in last 6 MONTHS and WHERE they were done?

1.______________________________________ 3. ____
2. ______________________________________ 4. ____

List All your Medications. ☐None

1.____ 5. ____
2. _______________________________________ 6. ____
3.____ 7. ____
4. _______________________________________ 8. ____

Do you have any ALLERGIES to any Medications? Yes ☐ No ☐ If yes, please list:

List any MEDICAL CONDITIONS you have had ☐ None ☐ High Blood Pressure ☐High Cholesterol ☐Heart Disease ☐ Chronic Kidney Disease ☐ Diabetes ☐Other _____________________________

Past Surgical History ☐ No ☐ Yes. If yes, please mention _____________________________________

Signature: ____ **Date:**________________________

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BILLING POLICY:

- Patient benefits will be verified with insurance prior to your office visit and co-pay will be collected at the time of service by cash or credit card (NO CHECKS).
    - ALL CO-PAYS ARE DUE AT THE TIME OF SERVICE.
    - Deductibles will be collected in full at the time of follow up appointment, after insurance has processed claims.
- Patients with outstanding balances will be requested to pay the balance in full, prior to their appointment, by cash or credit card (NO CHECKS).
- If amount remains unpaid after 90 days, the account will be referred to collection agency and an additional 10% fee will be applied to cover collection fee.

NO SHOW/CANCELATION POLICY:

- Any cancellation for an appointment *without a 24-hour notice*, depending on the circumstances of course, there will be charge a $25, that will have to be collected at the time of your next visit by cash or credit card.
- If you do not show up for an appointment, there will be a $25 charge, that will have to be paid at the time of your next visit.
- If you do not show up/cancel an appointments *3 times consecutively,* we will not be able to schedule any further appointments with our practice.

NOTICE TO ALL HMO PATIENTS

It is the patient's responsibility to obtain valid updated referrals for each office visit. If for some reason you do not have a referral to cover services here in our office, your appointment will be cancelled. Any office visits that do not have a referral to cover the services, the patient will be responsible for any balance, which your insurance will not cover without having a referral.

NOTE:

If you need to cancel your appointment prior to the scheduled date, and we are not in the office, you are always welcome to leave a message with our answering service at 708-283-2600.

PRINT NAME: ____

SIGNATURE: ______________________________ **DATE:** ______________

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PATIENT CONSENT FORM

☐ I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed the *Notice of Privacy Practices* containing a more complete description about the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that Southland Orthopaedics has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing to restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

HIPPA DISCLOSURE AUTHORIZATION

☐ I authorize Southland Orthopaedics to speak with and disclose information about my medical conditions to the following persons:

Name: ____________________________________ Relationship: __________________________________

Name: ____________________________________ Relationship: __________________________________

I, further authorize Southland Orthopaedics to contact me and leave messages on:

Home Phone: _____________________________ Cell phone: _____________________________________

Email: ____

This authorization will remain in place until rescinded by me.

____ ____
Patient Name Patient Signature

Date: ____________________