



Demographic & Insurance Information

Patient's Name _____ Age _____ Sex _____
 Birthdate _____ SSN _____ Marital Status _____
 Address _____
 City _____ State _____ Zip Code _____
 Telephone: Home # _____ Work # _____
 Employer Name / Phone # _____
 Spouse Name _____ SSN _____ Date of Birth _____
 Emergency Contact: Name / Relationship / Phone # _____
 Referring Physician Name _____
 Workers Comp injury? Yes No Date Injured: _____
 Automobile accident? Yes No Date: _____

INSURANCE INFORMATION

PRIMARY Insurance _____
 Name as listed on card _____ Birthdate _____
 ID # _____ Group Policy # _____ SSN _____
 Employer's Name / Address / Phone # _____

SECONDARY Insurance Student Athletic Protection, Inc.
 Name as listed on card Freed-Hardeman University Birthdate _____
 ID # 414 15 2710 N Group Policy # Freed-Hardeman SSN _____
1-800-232-1579 P.O. Box 20237 Kalamazoo MI 49019

RESPONSIBLE PARTY INFORMATION

(Complete only for a Child)

Name _____ Relationship _____
 SSN _____ Birthdate _____

CHECK IF ADDRESS IS SAME AS PATIENT'S , IF NOT THEN COMPLETE BELOW

Home Address _____
 City _____ State _____ Zip Code _____
 Telephone: Home # _____ Work # _____
 Employer's Name / Address / Phone # _____

Read the following release of information. Please sign and date

I agree to and authorize medical treatment as deemed necessary by Sports, Orthopedics & Spine. I hereby authorize Sports, Orthopedics and Spine to furnish information concerning my treatment to insurance companies as deemed necessary, and I hereby irrevocably assign to Sports, Orthopedics & Spine all insurance benefits payable to me by my insurance company, nor to exceed the charges shown. While any insurance or other protection related to the amounts due to Sports, Orthopedics & Spine may be hereby assigned to and payable directly to Sports, Orthopedics & Spine, the undersigned clearly understands that the obligation to pay Sports, Orthopedics & Spine is primarily on the patient, parent or legal guardian and the undersigned, and while any insurance received by Sports, Orthopedics & Spine will be applied to the patient's account, any part of the account, not so paid by insurance is nevertheless owing and payable by the undersigned. Sports, Orthopedics & Spine cannot accept responsibility for collecting insurance claims or for negotiating a settlement on a disputed claim. I understand that I am responsible for my account. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Sports, Orthopedics & Spine for any services furnished me by that clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration its agents any further information needed to determine these benefits or the benefits payable for related services. In case of default of payment, and if these accounts should be placed in the hands of a collection agency and/or attorney for collection, all collection fees, reasonable attorney's fees, costs and other expenses related to collection will be paid by the undersigned. Notice of dishonor, demand and protest are waived.

INITIAL: (Patient or responsible party) _____

I hereby authorize the attending physician to instruct a Nurse Practitioner / Physician Assistant to assist with certain aspects of my medical care. I understand that a Nurse Practitioner / Physician Assistant is not a licensed physician and may not treat or diagnose any illness, injury, or medical condition except under the supervision and direction of a licensed physician. I understand that I may revoke this authorization at any time.

INITIAL: (Patient / Guardian) _____

I have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (731) 427-7888 or by requesting one at this office.

* Please note: Any person whose name is on this sheet will have access to any information regarding the patient or his/her account. Must be 18 years old or older [mother, father, sister, brother, etc.]

I hereby authorize Sports, Orthopedics, & Spine to release information in my chart to the following person/persons about my account. This is valid as long as I have an account with Sports, Orthopedics & Spine.

1. _____ Date of Birth _____
2. _____ Date of Birth _____

(if applicable)

Athletic Trainer: _____ School: _____

Patient's Signature _____ Date _____
(Or responsible party)